Medicaid Purchase Plan Evaluation
Annual Report

for

Center for Delivery Systems Development
and the Division of Health Care Financing
Department of Health and Family Services

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Submitted by:
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Madison, Wisconsin

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I. Executive Summary

The Department of Health and Family Services, Center for Delivery System Development (CDSD) contracted with Innovative Resource Group (IRG), d/b/a APS Healthcare, Inc. (APS) to conduct an evaluation of the Wisconsin Medicaid Purchase Plan (MAPP). MAPP was created by Wisconsin Act 9 and was implemented on March 15, 2000. MAPP provides Medicaid coverage to individuals with disabilities whose family income is below 250% of the federal poverty level (FPL).

This report summarizes the research and findings of the third year of the evaluation (through June 30, 2003), and compares these findings with those from years one and two where possible. The evaluation has three components: (1) impact, (2) fiscal and (3) process. The impact evaluation examines the effect of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitors the effects of MAPP on state, federal and local Medicaid and long-term care funding. The process evaluation determines if the program was implemented equitably across the state and whether the program is efficient and effective.

With a third full year of data available for analysis, this report is able to provide a thorough analysis of the program's process, impact, and health care costs and utilization. The report focuses heavily on the impact and fiscal analyses. Specifically, it analyzes earnings and savings and how these variables affect the participants' experience in MAPP.

Two versions of a MAPP recipient survey are being administered. The first, or "Initial Survey," was designed to be administered to individuals who are new to the MAPP program. The second, or "Follow-up Survey," is administered to participants at 6, 12, and 24 months after enrollment. The Initial and Six Month Surveys completed data collection in 2003 and this report focuses heavily on the results of these surveys. Using the recipient survey results in conjunction with the available Client Assistance for Re-employment and Economic Support (CARES) data and the administrative program data already available, the evaluators were able to better assess the process and impact goals of the program during year three.

In addition, the current fiscal evaluation has built upon the analysis conducted last year. This year's report also includes an analysis of cost-effectiveness for individuals with varying levels of earned income. The fiscal analysis attempts to determine if MAPP is more cost effective for participants who are engaged in substantial work activity.

Initially, enrollment in MAPP was modest, but by the end of the first year of the program over 1,300 individuals had been enrolled. After automation of the MAPP enrollment process in January 2002, enrollment increased dramatically. As of July 31, 2002, there had been almost 3,800 individuals enrolled in MAPP at some point during the first two years of the program. Dramatic growth has continued throughout 2003. As of June 2003, a total of 6,220 individuals have ever been enrolled in the program. Currently, enrollment as of July 31, 2003 has reached 4,775 participants. New monthly enrollment averaged 141 individuals in the 12 months ending June 30, 2003. The majority of MAPP participants are between the ages of 35 and 64 with very few participants below the age of 25 or over the age of 65. The population is 51% female and

49% male. Sixty-four percent of all MAPP participants had been enrolled in Medicaid in the month prior to their MAPP enrollment and 86% had been enrolled in Medicaid at some point prior to their MAPP enrollment.

MAPP participants report monthly earnings ranging from $0 to $5,489, with an average of $270.09. Average monthly earnings continue to decline, dropping over $100 since year one. With automation has come an increase in low wage earners. It appears that MAPP is drawing many disabled individuals who are engaged in some type of minimal work activity, as opposed to substantial work. This appears to be an enrollment issue at the county level. Individuals whose income is over 150% of the FPL are required to pay a premium to participate in MAPP. The percentage of MAPP participants paying a premium averaged just under 12% per month for the first six months of 2003, down from 15% from the first six months of 2002. In June, 2003, monthly premiums ranged from $25 to $875. Premium collections for state fiscal year (SFY) 2003 generated $786,450 in revenue for the program. For an average month during SFY 2003, premium payments were equal to approximately 2.7% of total paid claims. During this period, Medicaid benefit expenditures on behalf of MAPP participants totaled just over $29 million.

In order to be eligible for MAPP an individual must be working or enrolled in the Health and Employment Counseling (HEC) program. In the first year of the evaluation, it was discovered that a significant number of MAPP participants reported $0 in earned income, but were not enrolled in the HEC program. As of July 2002, there were still a significant number of individuals (206) who reported $0 income, but were not participating in HEC. As of June 2003, there were 534 MAPP participants who reported $0 earnings, and only 94 current HEC participants. The high number of individuals who appear to be earning $0 and not participating in HEC raises concerns about the coordination of MAPP and HEC, specifically raising questions about whether or not economic support (ES) workers are verifying employment and making appropriate HEC referrals.

CDSD took a number of steps to improve the effectiveness of HEC. Seven new .2 FTE Regional HEC Screeners were hired and a Statewide HEC Coordinator employed by Employment Resources, Inc. (ERI) was assigned late 2001/early 2002. A considerable amount of effort was also directed toward improving outreach for HEC in 2002. ERI staff presented information on HEC and MAPP to new Pathways to Independence Benefits Counselors and Family Care Disability Benefits Specialists during a nine day benefits counseling training in February 2002. Outreach was also conducted through the Bureau of Community Mental Health's monthly teleconference to the Wisconsin Public Psychiatry Network on January 24, 2002.

The MAPP evaluation is scheduled to continue through 2004. As part of the ongoing evaluation, a detailed assessment of HEC is planned for early in 2004. Findings from the previous two MAPP annual reports will be used as a foundation for the upcoming HEC evaluation.

MAPP participants are allowed to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and are able to deduct Medical & Remedial Expenses (MRE) for the purpose of calculating premium amounts. Very few MAPP participants reported IRWE (2.3%) or MRE (6%) utilization. Despite continued attention from CDSD, IRWE and MRE reporting continues to

decrease over time. CDSD is currently developing new outreach activities aimed at improving the utilization of IRWE and MRE deductions.

It remains difficult to determine if MAPP is allowing participants to earn more money without fear of losing health insurance and to save toward independence. Recipient survey results suggest that MAPP does reduce anxiety over losing health care benefits after initial enrollment. However, a large percentage of the open-ended comments suggest at least some fear of losing health care benefits remains after enrollment. Saving among MAPP participants still appears to be less an issue of opportunity than an issue of ability. Most MAPP participants do not appear to have the available resources to begin saving at a significant level, and average earned income has steadily decreased over the first three years of the program. This finding is somewhat misleading given the continued growth of the program and increase in low wage earners. Once the MAPP population stabilizes, it will be easier to determine if the program is impacting the earnings and savings abilities of the program participants. Until then, it is very difficult to separate the effect of the new participants from the program effect.

The year three fiscal evaluation describes the effect of MAPP program participation on State and Federal Medicaid spending for health care services. The previous two *MAPP Evaluation Annual Reports* described data on Medicaid health care expenditures for MAPP program participants and comparable SSI or disabled adults who are not enrolled in MAPP. The third year MAPP fiscal analysis describes MAPP health care expenditures compared to expenditures for non-MAPP over the first three years of MAPP program implementation.

This analysis also examines differences in utilization and expenditure between MAPP participants who earn higher incomes and those with low, or no income. A major goal of MAPP is to provide low-cost health insurance to workers with disabilities whose earnings are too high to qualify for regular Medicaid, but who otherwise do not have insurance coverage. Therefore, this fiscal evaluation highlights the group of MAPP participants with substantial earned income.

The MAPP high-wage group tends to have lower spending than the comparison group on most categories of service, although not significantly lower. The low-wage MAPP participants have significantly lower home health care spending, and slightly higher spending on drugs, professional services, and other non-institutional services not elsewhere classified. Although MAPP participants tend to spend less than the comparison group through approximately 24 months of enrollment in the program, their rate of expenditure is higher during this period. It is expected that over time, the MAPP and comparison group rates of expenditure and total spending will converge and become very similar.

Otherwise, there is little distinction between MAPP participants' pattern of health care expenditures and those of comparable disabled Medicaid recipients not enrolled in MAPP. Whether or not one is eligible for Medicare or has prior experience with Medicaid seems to have a much greater influence on Medicaid spending per person per month than does MAPP program participation.[1]

[1] This phenomenon was analyzed and discussed in detail in the MAPP 2002 Annual Report.

The third goal of the program – to offer an effective, efficient and equitable program - was thoroughly addressed in the 2002 Annual Report. Data collection and analysis for the 2002 report reinforced many of the preliminary findings from the first annual report: 1) MAPP administration had been "disjointed" at the county level, 2) county staff exhibited varying levels of understanding regarding program policies and eligibility criteria, and 3) additional training to county ES workers and additional outreach among potential program participants was needed. Feedback from the ES Worker Survey and MAPP recipient survey substantiated these findings and provided tangible evidence that MAPP was slowly becoming more effective, efficient and equitable across the state. Similarly, Health and Employment Counseling (HEC) refinement and reorganization improved the consistency of MAPP administration across the state, and provided a limited amount of community outreach.

Based on the findings presented in the 2002 report, CDSD has become acutely aware of the need for further community outreach regarding MAPP, specifically MAPP eligibility criteria. CDSD has been working on improving the effectiveness of MAPP, possibly through the creation of Club MAPP. Club MAPP would be an extensive "in-reach" program designed to provide the current MAPP population with succinct information regarding the work incentives, supports and other benefits available through enrollment in MAPP.

Independence Accounts (IAs) continue to be an underutilized benefit. Only 1% of all participants in June 2003 reported having IAs, a figure that has remained consistent during the first three years of the program. In addition, 38% of all accounts report a zero balance; providing further evidence that MAPP participants continue to find it difficult to save towards independence. More detailed IA data has not been collected from county workers through CARES; however, the evaluators and CDSD expect this to improve over time. CDSD continues to work to obtain more detailed IA information.

All evaluation data and analyses related to measuring work, earned income and determining premium liability strongly support narrowing the definition of work within the current federal guidelines. The definition of employment is confusing to many county workers and participants, causing wide variation among county workers as to what is considered valid employment. The definition of employment impacts enrollment and premium liability; therefore, the State could address several program issues by redefining "work" in the context of MAPP, bringing the program closer to its original intent of providing an alternative MA program for working disabled who are capable of "substantial work." CDSD continues to work towards a new definition of work that meets the intent of the program and also fits within existing federal guidelines.

Findings from the second annual report raised the possibility that the impact of MAPP may be masked by the large number of participants who report very low earned income. To address this possibility, the year three annual report analyzed specific recipient survey findings by earned income level as reported in CARES. A correlation matrix was constructed using earned income, family size, relation to the Federal Poverty Level (above/below), gender, race, medical status codes and rural urban commuting areas (RUCA) consolidated codes to determine if key recipient survey questions were related to any of these factors. Specific attention was paid to earned income. Interestingly, few questions were significantly related to level of earned income.

Responses were generally similar among all income groups on key issues related to MAPP. Differences are highlighted in the body of the report.

The distribution of earned income among MAPP participants was also examined. There are disproportionately more $0 wage earners in Milwaukee, Kenosha, Washburn and LaCrosse Counties[2]. In addition, Milwaukee and Dane Counties represent a disproportionate number of high wage earners.[3] These findings suggest one of two things is occurring in these counties. Either the county populations tend to cluster on the very low and very high ends of the earnings spectrum, or there is a process issue at work during the enrollment and recertification process in these counties that artificially increases the number of very low or very high earners. For instance, ES workers in these counties may put more emphasis on finding ways to qualify their clients for MAPP, such as doing yard work for neighbors or taking care of neighbors' pets for some type of in-kind payment; whereas, the other counties may only query their clients about jobs that pay actual wages. In either case, the MAPP enrollment criteria are being interpreted very differently, which would lead to differing levels of enrollment and different demographic characteristics among program participants enrolled by these counties. Given that most survey respondents indicated a lack of knowledge regarding MAPP, and several also point out that their county workers have a less than thorough understanding of the program, it would not be surprising if several process issues are affecting MAPP enrollment.

In the case of Milwaukee and Dane Counties, it seems more likely that they would have larger populations at the very low and very high ends of the wage distribution, but in Washburn County, one would not expect their participants to cluster at the $0 earner level, unless there is a process effect occurring during enrollment. High income jobs are more prevalent in Milwaukee and Dane Counties, and it is likely that they also have a larger percentage of low income individuals, both of which suggest that other factors besides process issues could be at work in these counties. However, in the case of LaCrosse, Kenosha, and particularly Washburn County, a process affect is more likely.

Lastly, initial and follow-up responses were also tested for statistically significant differences. Again, very few significant differences were found. However, follow-up respondents were able to save significantly more money in the past six months than initial respondents, suggesting that MAPP does allow program participants to save more once enrolled in the program. Despite saving more, follow-up respondents reported being significantly less satisfied with MAPP than initial respondents. Few other differences were significant.

Further Analyses

Through discussions with CDSD, the evaluators have prioritized a list of future MAPP evaluation activities to be completed during the 4th quarter of 2003. These activities are designed to strengthen the findings presented in this report, as well as fill gaps where impact, cost-effectiveness or process questions remain unanswered. Using some of the findings from this report, in conjunction with possible new data collection, the evaluators will examine the following topics:

[2] Not all counties were checked for this analysis; however, the counties identified above have the largest differences in percentage of $0 wage earners relative their proportion of the entire MAPP population.
[3] High wage earners are those earning more than $1,249 per month.

- Complete administration of the 12-Month, 24-Month and Disenrollment Surveys and provide a final analysis of each.
- Further examine the extent to which MAPP participant earnings come from self-employment or in-kind compensation.
- Examine MAPP enrollee tenure, including a profile of the length of participation in the MAPP program.
- Use the CDPS grouper to generate a co-morbidity score for all MAPP participants based on diagnosis and utilization.
- Consider methods for collecting data on participants who earn at substantial levels, but choose to disenroll from MAPP.
- Analyze the geographic distribution of comments from the ES Worker Survey to target areas for further program outreach/training.
- Work with other states through the National Consortium for Health Systems Development (NCHSD) to design a data collection strategy/instrument to assess barriers to work for buy-in participants.
- Identify a mechanism for collecting more information on utilization of IAs, IRWEs and MREs.

II. Background

Section 4733 of the Balanced Budget Act of 1997 (Public Law 105-33) allows states to make available a new Medicaid subprogram for individuals with disabilities whose family income is below 250% of the federal poverty level ($22,450 in 2003 for an individual). In Wisconsin, this subprogram is called the Medicaid Purchase Plan (MAPP). MAPP was created by 1999 Wisconsin Act 9 and was implemented on March 15, 2000.

Evaluation Contract

Under a contract with the Department of Health and Family Services (DHFS), Center for Delivery System Development (CDSD), APS Healthcare, Inc. is conducting an ongoing evaluation of MAPP. This annual report summarizes findings from year three of the evaluation, which began July 1, 2002, and ended June 30, 2003.

This evaluation was conducted in partnership with The Management Group (TMG). APS offers diversified health care consulting services, specializing in data analysis and reporting, program evaluation, survey administration and other technical health care services. TMG is a management consulting and services organization with experience in health and long-term care.

Evaluation Components

The MAPP evaluation has three components: impact, fiscal and process. The impact evaluation examines the effects of MAPP on enrollee's employment, earnings, savings, health care utilization and health status. The fiscal evaluation monitors the effects of MAPP on state and federal Medicaid funding and examines the effects of MAPP on locally funded long-term care services. Finally, the process evaluation determines if the program is implemented equitably across the state and whether the program is efficient and effective. It also measures participant satisfaction through recipient and disenrollee surveys.

III. Program Overview

Program Goals
The purpose of MAPP is to provide people with disabilities an opportunity to overcome key barriers to employment. Specifically, the three stated goals of the program are to:

- Encourage people with disabilities to earn more income without risking loss of health and long-term care coverage.
- Allow people with disabilities to save and make purchases toward their independence, similar to opportunities currently available to the majority of the workforce.
- Offer an effective, efficient and equitable program to allow people with significant disabilities the opportunity to work without jeopardizing their health care coverage.

Eligibility Criteria
In order to be eligible for MAPP, an individual must be a Wisconsin resident and at least 18 years old. They must be determined to be disabled by the DHFS Disability Determination Bureau (DDB). Participants must also be working or enrolled in a Health and Employment Counseling Program (HEC) and have countable assets under $15,000. Countable assets include items such as cash savings, life insurance policies, and stocks and bonds, but do not include an individual's home or vehicle.

Program Features
In addition to providing health care coverage, the MAPP program includes a number of features designed to foster independence.

Enrollment in the Health and Employment Counseling (HEC) program provides individuals an opportunity to enroll in MAPP to secure health care coverage, while seeking employment. Enrollment in the HEC program temporarily fulfills the MAPP work requirement by requiring development of an employment plan consisting of benefit counseling, employment barriers assessment, and a plan to address all identified barriers to employment. Upon approval of the employment plan, the MAPP work requirement is waived and the applicant becomes eligible for the MAPP program for at least nine months, with the opportunity for a three-month extension if necessary. If the enrollee remains unemployed after the three-month extension, he/she loses MAPP program eligibility. The HEC program is administered by Employment Resources, Inc. (ERI) under contract with the CDSD.

Once enrolled in MAPP, participants can establish Independence Accounts (IAs), which are intended to foster savings for items that increase personal and financial independence. By establishing an IA, MAPP participants can save earnings above the $15,000 countable asset limit for the program. Total annual deposits to IAs can not exceed 50% of gross earned income each year.

MAPP policies include a work exemption provision for individuals who are sick and need to take off of work for a period of time. Participants who have participated in MAPP for at least six months are eligible for the exemption. The exemption itself can last up to six months and is limited to two exemptions every three years.

Health Care Coverage

The MAPP program offers health care coverage to eligible individuals. Family coverage is not available. However, if more than one family member has a disability, each person with a disability may be eligible for the program if he/she meets all of the eligibility requirements.

MAPP participants are eligible for the same health care services available to any other group through Wisconsin's Medicaid program. These services are available at no cost to individuals whose total income is less than 150% of the federal poverty level (FPL). Individuals with a total income that meets or exceeds 150% of the FPL are required to pay a premium to participate in the program.

Premiums Requirements

Monthly premiums for MAPP are based on an individual's monthly income and family size. Spousal or other family member income is not counted in the premium calculation, but those individuals would be counted when determining family size. The amount of a MAPP recipient's premium is based on his/her adjusted earned and unearned income.

Unearned income includes Social Security benefits, disability benefits and pensions. Adjusted unearned income equals total unearned income less the following deductions:

- Standard living allowance ($655 per month for calendar year 2003)
- Impairment-related work expenses (IRWEs), such as transportation to employment
- Medical and remedial expenses (MREs), such as attendant care

Earned income is income from paid or self-employment. Adjusted earned income equals gross earned income before taxes and any remaining income deductions from one's unearned income. In other words, if one's unearned income is less than the sum of the allowable deductions, the difference can be applied as a deduction to one's earned income.

Premium income is the sum of one's adjusted unearned income and 3% of one's earned income. In the following example, the applicant receives an $850 monthly Social Security Disability Insurance (SSDI) payment and earns $1,200 per month. He spends $50 a month on cab fare to work and has $10 in medical payments per month.

Calculation of Monthly Premium

Monthly Unearned Income =	$ 850
Less Standard Living Allowance	*$ 655*
Less IRWEs	*$ 50*
Less MREs	*$ 10*
Adjusted Unearned Income	**$ 135**
Monthly Earned Income=	$1,200
Less Remaining Deductions	*$ 0*
Adjusted Earned Income	***$1,200***
	x .03
	$ 36
	+ 135
Premium Income	$ 171
Premium Amount[4]	$ 150

[4] Premium income between $150 and $175 results in a premium of $150. A premium Schedule is included as *Attachment A* in section VIII Appendix.

IV. Impact Evaluation

The purpose of the impact evaluation is to measure the impact of MAPP on participants' ability to earn more and save toward their independence while retaining their health care coverage. In addition, the impact evaluation tracks participants' health status and health care utilization over time.

Information for the impact evaluation is drawn from a number of sources including:

- Recipient survey data (Initial and Six Month Follow-Up)
- Disenrollment Survey data
- MAPP application data from the Client Assistance for Re-employment and Economic Support (CARES) system
- Medicaid eligibility data
- Medicaid claims data
- Long-term care services data from the Human Services Reporting System (HSRS)
- HEC database data

Enrollment Trends

Since the program's inception, MAPP enrollment has grown steadily. However, beginning with the automation of the MAPP application process in CARES in January 2002, the program has experienced significant growth. Total enrollment in July 2002 was 2,933 individuals, more than double the enrollment in July 2001. Since automation (January 2002), enrollment has grown by over 150%. In the six months prior to automation, new enrollment averaged 82 individuals per month. In the six months after automation, 222 individuals were enrolled each month, on average.[5] In the last year, enrollment has averaged 141 individuals per month. As of June 2003, a total of 6,220 individuals had ever been enrolled in the program. Active enrollment as of July 31, 2003 reached 4,775 individuals, an increase of 1,842 program participants since last year.

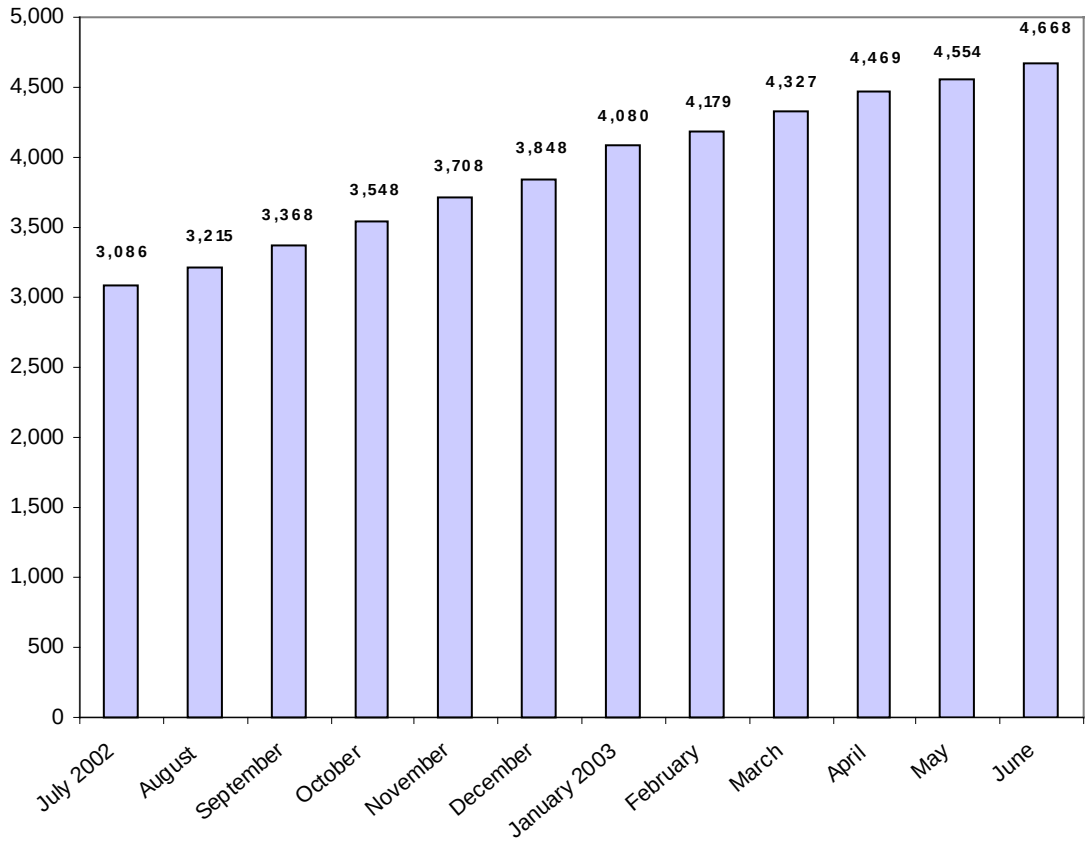
The growth in 2002 appeared to be a direct result of automation of the MAPP eligibility process in CARES. As noted in the first annual report and reiterated in last year's report, the complexity of the manual enrollment process was seen by many county workers as a deterrent to enrollment. Consequently, it was expected that by making it easier for economic support (ES) workers to enroll individuals in MAPP through automation, MAPP enrollment would increase.

However, steady growth has continued to occur through the first half of 2003, suggesting that something other than the automation of the enrollment process is at work. The continued pace of enrollment may reflect a better awareness of the program's availability among consumers, advocates or county workers. Although the continued steady growth of the program does not diminish the enrollment effects of providing a more accessible and efficient enrollment process, it does suggest the existence of a distinctively underserved disabled population in need of medical coverage while attempting to work. The following chart summarizes enrollment from July 2002 through June 2003.

[5] Automation was implemented in mid January. The average includes January through June 2002.

* A universe is a view of the data in a format that eases analysis.

Monthly MAPP Enrollment State Fiscal Year (SFY) 2002-03



Please see *Attachments B, C and D* in section VIII Appendix for month by month summaries of enrollment, disenrollment and pre-and post-MAPP Medicaid eligibility periods.

Dane County has enrolled 10% of the total MAPP population, but only 5.8% of the statewide disabled Medicaid population. In July 2002 these figures were 11% and 5.7%, respectively. MAPP enrollments through Milwaukee County (8.7%) are up again in 2003, marking the second annual increase since program inception. However, Milwaukee County currently accounts for over 29% of the entire state disabled population.[6] These figures suggest that Milwaukee County continues to have difficulty enrolling MAPP participants. MAPP participants are also concentrated in Kenosha County (5.1%), Waukesha County (3.5%), Winnebago County (3.4%), and LaCrosse County (3.3%).

MAPP outreach has been an issue throughout the first three years of the buy-in. Through their participation in the recipient surveys or through direct contact with the evaluation staff or county

[6] Milwaukee County program enrollment is discussed further in the Process section of the report.

workers, many program participants have indicated that they know very little about MAPP, and oftentimes have no idea that they have been enrolled in the program. It has been speculated that MAPP enrollment may be higher in counties where other related programs have a strong presence at the county level.

Two programs were targeted for analysis: Wisconsin Pathways to Independence (PTI) and Family Care. PTI seeks to remove barriers to employment for people with severe disabilities and provide ready access to the comprehensive help they need in order to work. PTI offers improved health care insurance options, specialized benefits consultants, vocational planning specialists, and an individual team of employment advisors and a full range of Division of Vocational Rehabilitation services. Participants are able to consult with a single team which can offer coordinated access to all professionals and programs that may assist them in achieving their employment goals. These local Comprehensive Assistance Networks mobilize all available vocational, educational, health and supportive services.[7] Each organization works with the local vocational rehabilitation district to assure needed training, worksite accommodations and adaptive aids.[8]

Family Care was designed to provide cost-effective, comprehensive and flexible long-term care that fosters consumers' independence and quality of life, while recognizing the need for interdependence and support. Nine counties are currently piloting Family Care: LaCrosse, Milwaukee, Richland, Fond du Lac, Portage, Marathon, Jackson, Trempealeau and Kenosha.

Family Care has two major organizational components:

1. Aging and disability resource centers, designed to be single entry points where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.

2. Care management organizations (CMOs), which manage and deliver the new Family Care benefit, which combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, circumstances and preferences. [9]

It was speculated that the local presence of these programs may positively impact MAPP enrollment; however, very few MAPP participants are also enrolled in PTI (84 current participants) and Family Care (116 current participants). Family Care in Milwaukee County currently only serves the elderly; therefore, it was not included in the following analysis. Just under 7% of all MAPP participants at any point in time have been enrolled in the remaining 4 CMO counties, while 9.1% have been enrolled in the resource center only counties. In comparison, just over 5% of the disabled Medicaid population in Wisconsin comes from the four remaining CMO counties, and 5.8% of the disabled state population comes from the four resource center only counties. These findings suggest that Family Care may be funneling people

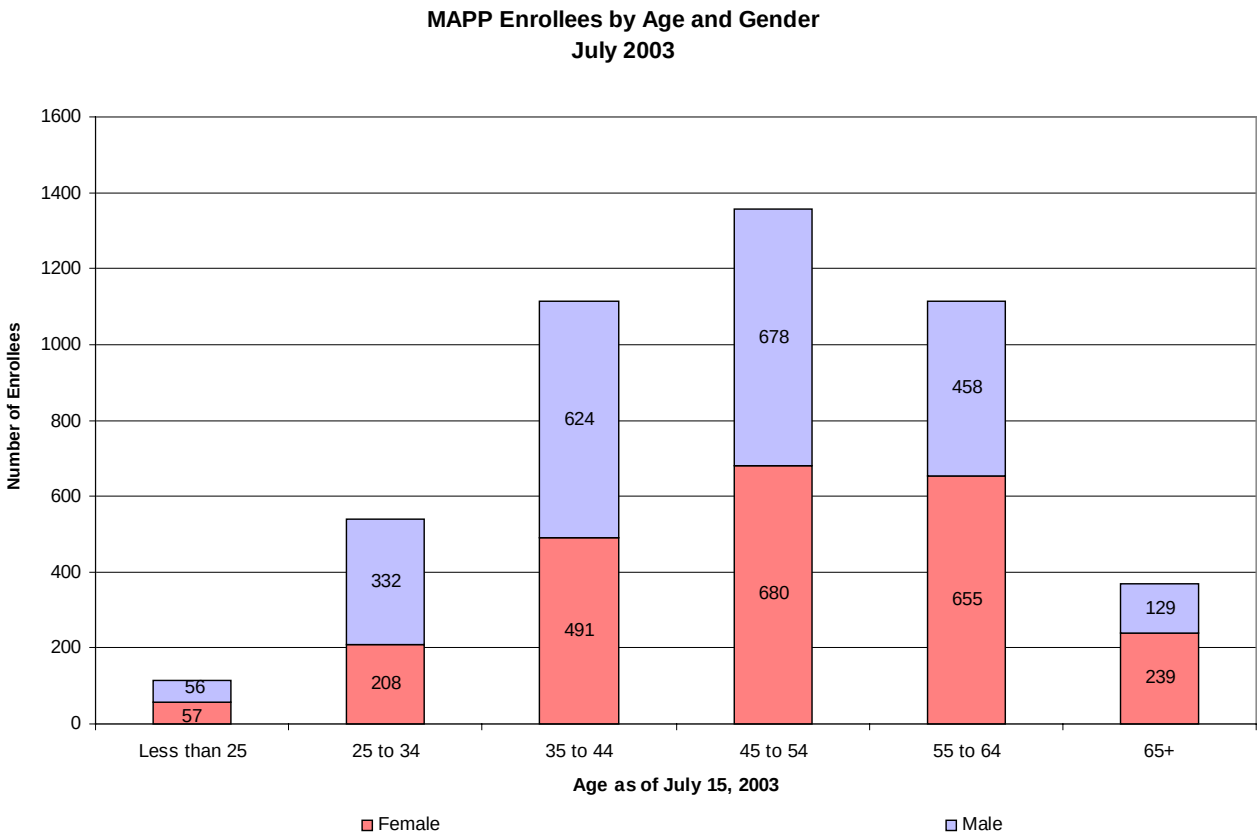
[7] PTI has a presence in the following counties: Polk, St. Croix, Pierce, Barron, Dunn, Chippewa, Eau Claire, Buffalo, Trempealeau, Jackson, LaCrosse, Monroe, Vernon, Crawford, Juneau, Marathon, Wood, Portage, Adams, Sauk, Dane, Rock, Jefferson, Walworth, Waukesha, Milwaukee, Racine, Kenosha
[8] Source: http://www.dhfs.state.wi.us/WIpathways/ProgramInfoDocs/summary.htm
[9] Source: http://www.dhfs.state.wi.us/LTCare/INDEX.HTM

into MAPP as an alternative to Family Care in the RC only counties, but also providing some limited outreach in the four CMO counties outside of Milwaukee.

Attachment E in section VIII Appendix provides a full listing of MAPP and disability-related Medicaid certifications by county.

Demographic Data

As of July 15, 2003, there were 4,607 individuals enrolled in MAPP. The following chart provides a breakout of the population by age and gender.



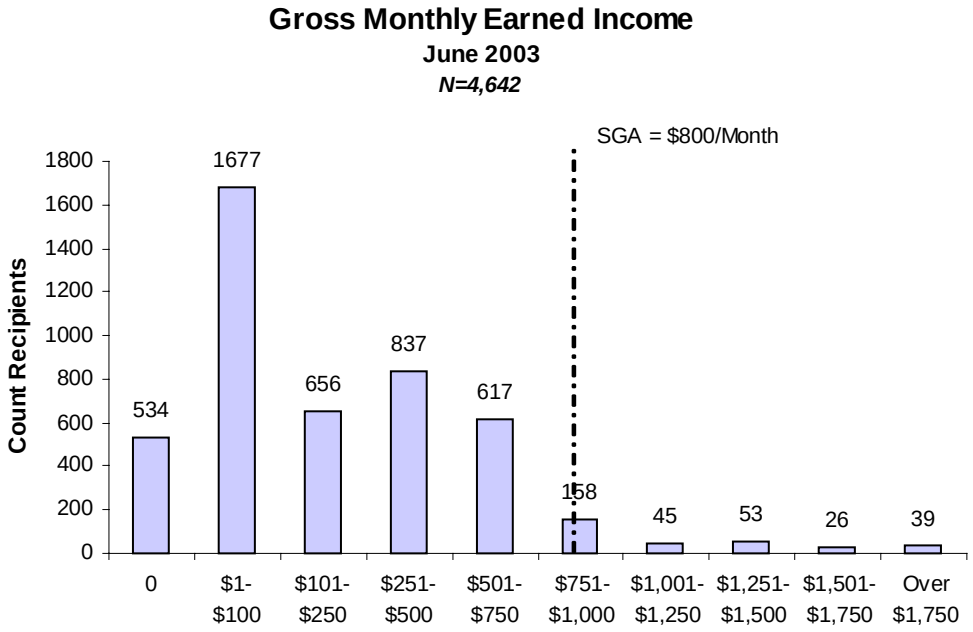
As the chart illustrates, almost 54% of the participants are between the ages of 35 and 54. Approximately 49% of the population is male. The proportion of men and women varies within each of the age categories, with the most disproportionate ratio occurring in the over 65 category, where 65% of the participants are female. Women represented 62% of the over 65 participants in year one and 68% in year two.

In June 2003, MAPP participants had earned income ranging from $0 to $5,489 per month with an average of $270.09 and a median of $120.02[10] The 2003 figures represent a continued decline

[10] These figures include 4,642 participants with income information available through the CARES system. Earned income figures represent the latest monthly earned income reported by participants through CARES as of June 2003.

in average earnings from years one and two of the evaluation.[11] MAPP participants in year one averaged $393 per month, while participants in year two averaged $321.11 per month.[12] The drop in average monthly income reflects the large number of new participants, most of whom enter MAPP with very low cash earnings from work.

Average and median earned income in year three continue to be well below the substantial gainful activity (SGA) level of $800 per month used by the federal government to determine social security disability eligibility. Disabled individuals earning above $800 per month risk losing their federal disability benefits[13], which may account for the large drop-off in wage earners above the SGA level. The following table shows the distribution of these participants by the amount of their monthy earned income.



Source: CARES June 2003

MAPP is a work incentive program, intended to maximize the participant's ability to work and increase their earned income. Therefore, a goal of this evaluation is to determine whether or not MAPP participants are able to increase their earned income over time. Several aspects of the evaluation have attempted to address this issue, including the Initial and Follow-up Surveys,[14] and general observations from county workers and MAPP participants. To further address this

[11] CARES earned income figures are self-reported, potentially calling into question the accuracy of the data. As a check on the validity of these data, a comparison was conducted between the CARES figures and the Department of Workforce Development (DWD) Unemployment Insurance (UI) system for 4th quarter 2002 MAPP participants. Over 50% of the participants (N=2,150) had differences of less than $100 and 72% had differences of less than $200, supporting the validity of the CARES income data.

[12] Year one earned income data came directly from the MAPP paper applications submitted by each county to CDSD and aggregated by APS.

[13] Individuals earning above $800 per month are only at risk of losing their Social Security Disability Income (SSDI) benefit.

[14] Each survey is discussed in detail later in the report.

question, the evaluation team conducted an analysis of reported earned income from the CARES system using June 2002 and June 2003 data. Differences in earned income over that 13 month period were calculated for the 2,154 individuals with valid data in both months.

Over 38% of the individuals in the analysis showed an increase in earnings during this period, while 34% showed a decrease. Twenty-eight percent showed no change during this period. Average earnings per month for the 38% who increased their earnings went from $344 in June 2002 to $463 in June 2003, an increase of 35%. The program participants with lower earnings dropped from $405 in June2002 to $247 in June 2003, a 39% decrease in average earnings.

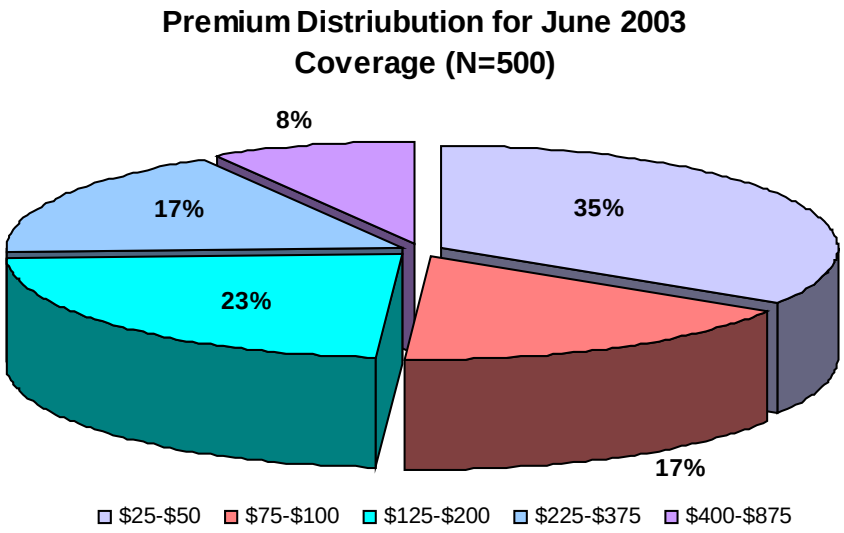
Although the 13 month period selected for this analysis artificially limits the number of individuals included in the analysis, a period of 13 months was necessary to allow for updates to the CARES income data. CARES income data is only required to be updated when a participant self-reports an income change, or at the participant's one year re-certification date. As such, it was necessary to select a time period that would capture at least one re-certification in order to reflect actual changes in income. It is encouraging that a larger percentage of participants exhibit a positive change in income during this period. Further analysis in 2004 based on recertification dates, and in conjunction with county staff and CARES data administrators, may help to solidify the changes observed in this analysis.

Premium Status

MAPP participants whose gross individual income exceeds 150% of the federal poverty level (FPL), currently $13,470 for an individual, for their family size are subject to a premium. The majority of MAPP participants are not paying a premium to participate in MAPP. According to Medicaid eligibility data, the percentage of MAPP participants paying a premium averaged 11.7% per month for the first six months of 2003, down 3% from the first six months of 2002. *Attachment F* in section VIII Appendix provides a monthly summary of MAPP enrollment by premium status.

The amount of the MAPP premium varies dramatically among participants. For the June 2003 benefit month, premiums ranged from $25 (the minimum possible premium amount) to $875. Of the 500 individuals paying premiums for July coverage, just under 35% were paying either a $25 or $50 premium[15]. Another 17% were paying a $75 or $100 premium and 23% were paying between $125 and $200. The remaining 25% pay premiums in excess of $200 per month. The average premium collected was $153.04. The average premium amount has remained relatively stable over the life of the program. The sum of all premiums collected in June 2003 was $74,225. See the graph below for a summary of premium payment amounts.

[15] The premium schedule is set at increments of $25.



For state fiscal year (SFY) 2002-03, MAPP premiums have generated $786,450 in revenues, an increase of $295,065 from the previous fiscal year. Premium collections help to offset MAPP program costs. For an average month during the 2003 SFY premium payments were equal to approximately 2.7% of total paid claims, down from 3.8% for SFY 02. *Attachment G* in section VIII Appendix provides a month by month summary of premium and claims payments for SFYs 2001, 2002 and 2003.

Medicaid and MAPP

The vast majority of MAPP participants were Medicaid eligible prior to their enrollment in MAPP. Of the 5,915 individuals who were eligible for MAPP between January 2000[16] and May 2003, 64% were enrolled in Medicaid in the month prior to their MAPP enrollment. Over 5,100 (86%) were enrolled in Medicaid at some point in time prior to their MAPP enrollment. Eighty-three percent of the MAPP participants eligible in June 2003 also had Medicare coverage. From the program's inception through May 2003, more than 1,409 individuals have disenrolled from MAPP at least once. The majority of the individuals who disenroll from the program subsequently re-enroll in non-MAPP Medicaid. Almost 94%, or 1,319, of program participants had at least one post-MAPP Medicaid eligibility segment.[17] The majority of the post-MAPP Medicaid eligibility segments were SSI-related, as illustrated in the following table.

[16] While MAPP began in March of 2000, there were a number of individuals who had their initial eligibility backdated to January 2000. Under Medicaid policy, eligibility can be backdated three months from application if the individual would have met all eligibility criteria for those months.

[17] Please note that an individual may have more than one disenrollment and more than one post-MAPP eligibility segment. For example, as a result of changing income, a participant could have disenrolled from MAPP in February 2001; been on SSI-related Medicaid in March and April; re-enrolled in MAPP for May and June; disenrolled from MAPP and became eligible for non-MAPP Medicaid a second time.

Post-MAPP Medicaid Eligibility By Medical Status Group	
SSI-Related	766
Waiver	184
SSI	131
Medicare Beneficiaries	104
BadgerCare	57
Nursing Home	43
SeniorCare	12
AFDC	8
Healthy Start	5
Family Planning Waiver	4
Family Care (non-MA)	4
Foster Care	1
Total	**1,319**

Health and Employment Counseling (HEC) Enrollment

Changes to HEC following the first Annual Report had an impact on HEC enrollment in 2002. At the end of June 2001, there were 35 MAPP participants representing 27 counties enrolled in HEC. By July 2002, 126 MAPP participants had been enrolled in HEC at some point, representing 36 counties. As of July 2002, there were 68 active HEC participants. HEC enrollment continues to increase with overall MAPP enrollment. Currently, 94 individuals are enrolled in the HEC program, and total enrollment since inception is 258.

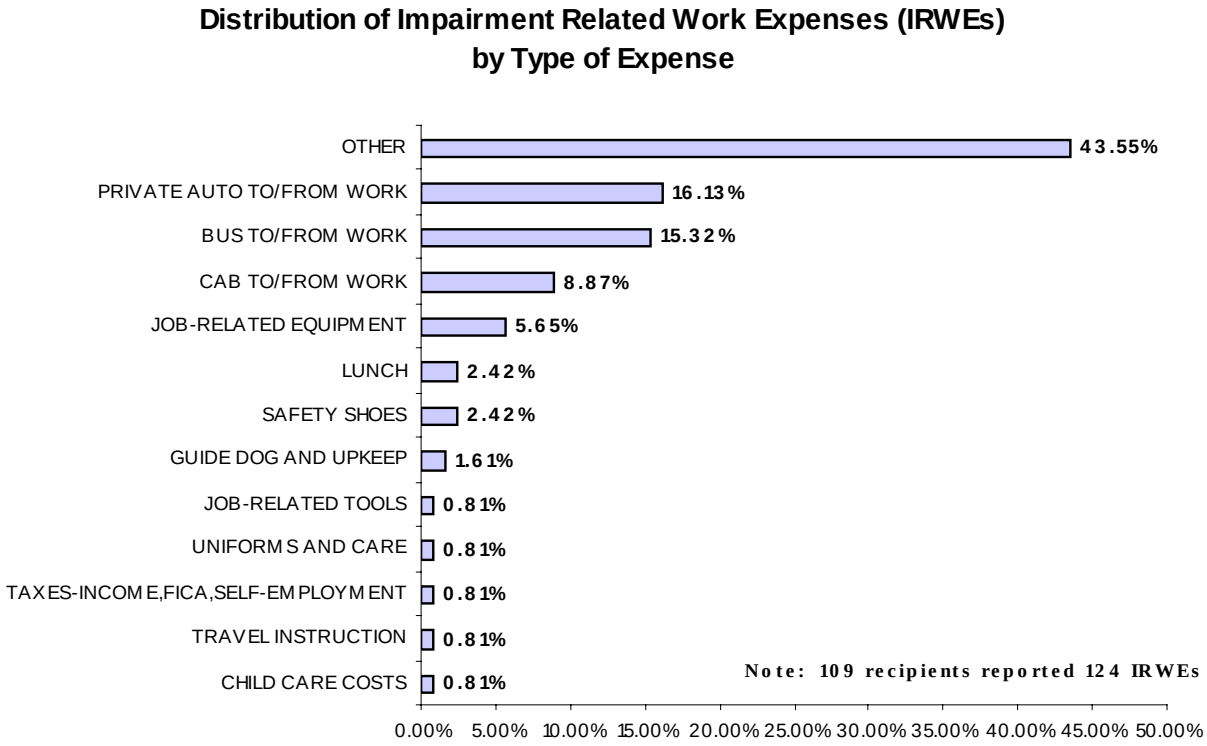
As part of the ongoing MAPP evaluation, a detailed assessment of HEC is planned for early 2004. Findings from the previous two MAPP annual reports will be used as a foundation for the upcoming HEC evaluation.

MRE and IRWEs

MAPP participants are allowed to deduct Impairment Related Work Expenses (IRWEs) from their income for the purposes of calculating financial eligibility and premium amounts for MAPP and are able to deduct Medical & Remedial Expenses (MREs) for the purpose of calculating premiums amounts. Information on MREs and IRWEs is collected by ES Workers as part of the MAPP application process. Detailed lists of IRWEs and MREs can be found in *Attachment H:* IRWEs and MRE Examples in Section VIII Appendix.

It appears that very few applicants are reporting MRE or IRWE expenses. June 2003 CARES data indicate that only 109 of 4,642 (2.3%) MAPP participants report IRWE expenses. This is down for a second consecutive year. The minimum expense identified was $1 and the maximum was $4,000. While total reporting is down, the average expense is up by $42 over year two and almost $100 over year one, amounts greater than could be expected from inflation alone. Transportation expenses accounted for over 40% of all expenses. The following chart categorizes the 124 reported expenses, representing 109 participants, by category as reported in

CARES. However, the frequent use of the "other" category limits our ability to fully assess the functional needs of MAPP participants.



Over 6% of the applicants identified MRE expenses in June 2003. Just under 10% of applicants identified MRE expenses in 2002. The average MRE expense of $179.70[18] did not change from 2002. The minimum expense was less than $1 and the maximum expense was $8,844. Unfortunately, CARES reported all expenses as "out of pocket medical/remedial;" therefore, there is no way of identifying the types of expenses incurred by MAPP participants.

Although the use of IRWEs is still relatively new, ES workers have had 3 years to become familiar with this benefit, yet IRWE use has remained minimal. MREs are used throughout the Medicaid system and should be familiar to most county workers. As of last year's report, it was hoped that ES workers would begin taking advantage of the 38 MRE codes available to describe MREs in order to provide more detailed information regarding these types of expenses. Unfortunately, the use of the other MRE codes did not occur. Additional training on the use of IRWEs and MREs appears to be needed to increase awareness and identification of these expenses among county workers. General outreach describing the benefits of participation in MAPP is currently being organized by CDSD.

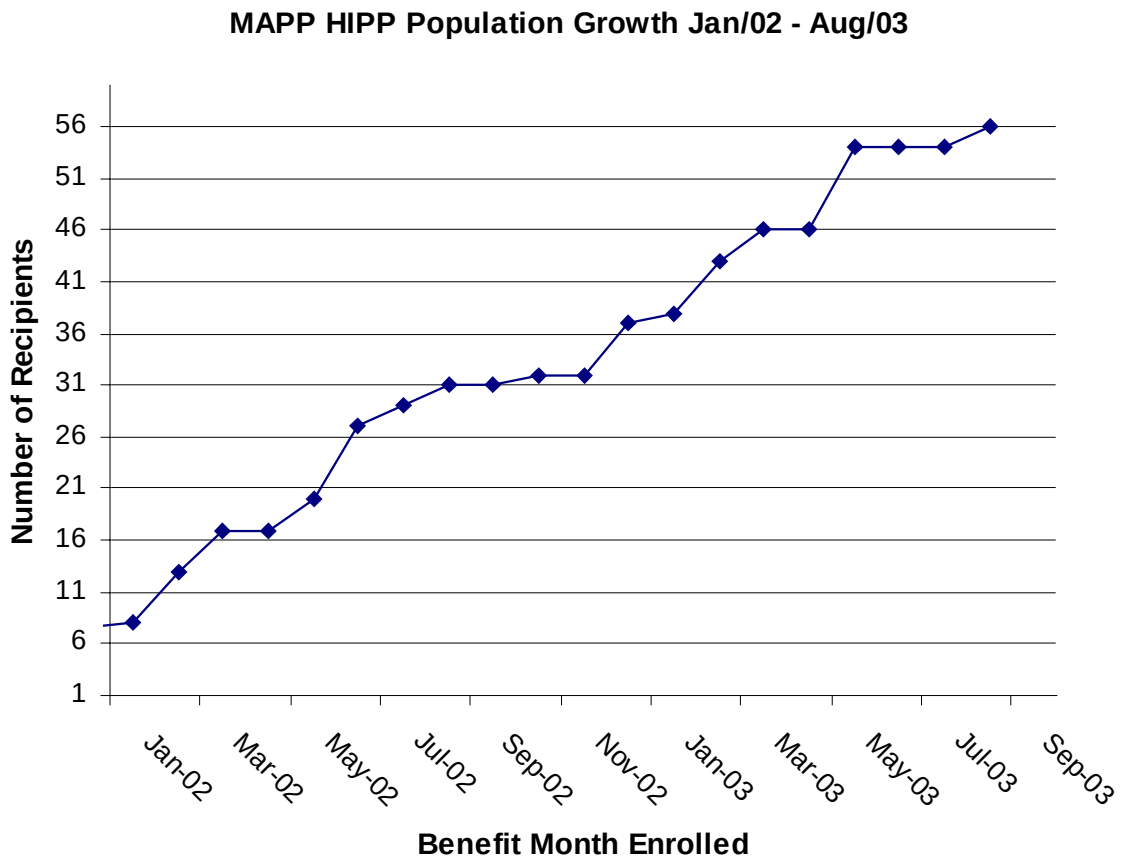
Health Insurance Premium Payment (HIPP)

Under HIPP, Medicaid pays the "employee share" of the participant's or the participant's spouse's employer sponsored health insurance premium if it is cost-effective, thus reducing

[18] This figure represents an average MRE expense per person who reported MRE expenses. 298 MAPP participants reported 318 MREs.

Medicaid expenditures. This benefit became available to MAPP participants in October 2001. The average monthly employee share for the employer sponsored insurance is $93.65. The average cost has remained stable over the last year. Currently, 56 MAPP participants are participating in the HIPP program. Employers ranged from Wal-Mart to Harley Davidson, covering retail, manufacturing, banking and customer service related employers. HIPP is a relatively new program, but enrollment has already doubled in the last year.

Although HIPP enrollment continues to increase, the relatively small number of HIPP participants suggests that either employer sponsored health insurance is not available to most MAPP participants, HIPP is not cost-effective for most participants, or county workers are not familiar with the benefit. The graph below shows HIPP enrollment from January 2002 through August 2003.



Source: Electronic Data Systems (EDS). The Medicaid Fiscal Agent.

It is expected that HIPP will be cost-effective for Wisconsin Medicaid by allowing the MAPP participant's employer sponsored insurance policy to cover most medical expenses. To test this assumption, the evaluators conducted a preliminary analysis of Medicaid claims expenditures for HIPP participants pre-participation and post-participation in January 2002. Only 28 individuals were enrolled in HIPP and had sufficient pre- and post- enrollment Medicaid eligibility to qualify for the analysis. Per-member-per-month expenditures increased from $310.99 to $477.65 for the 28 participants in the analysis. Given the small number of observations, the difference is not significant; however, it does contradict the assumption that Medicaid costs should go down

following enrollment. It may be useful to discuss this analysis with HIPP staff and refine the parameters for future evaluation.

Initial and Six Month Follow-Up Surveys

Administration

Two versions of the MAPP recipient survey are being administered. The first, or "Initial Survey," was designed to be administered to individuals who are new to the MAPP program. The second, or "Follow-up Survey," is administered to participants at 6, 12, and 24 months after enrollment. Evaluation staff draws a monthly sample of participants for each survey. To minimize the burden to MAPP participants, and to reduce the cost of the evaluation study, the evaluation staff select a random sample of participants for questionnaire mailing and telephone interviewing each month, rather than administering a questionnaire to all MAPP participants. The sample survey uses probability sampling. This enables staff to give appropriate weight to each respondent so that the sample is representative of the whole population of MAPP participants over the course of the study period.

The MAPP Initial and Follow-Up surveys were field tested in mid-February, 2001 and surveys were mailed to the first cohort of MAPP participants in late February. Subsequent cohorts were drawn monthly, beginning in April 2001. Each cohort consists of two groups – new MAPP participants receiving the Initial Survey, and participants receiving the 6, 12 or 24-month Follow-up Survey.

The following protocol for contacting survey recipients has evolved during the course of the evaluation. A maximum of five attempts are made to contact each sample participant. At least two of the five attempts are made after 4:00 p.m. on weekdays or on Saturday. When a voice contact is made, the participant is invited to complete the survey questions at that time, or to schedule another time for the interviewer to call back and complete the survey. If the participant does not wish to complete the survey on the telephone, he/she is offered the option of completing the survey and mailing it back to TMG. A postage paid return envelope is then mailed to the participant to facilitate completion of the survey. If the participant (or a family member or guardian) declines to complete the survey, their name is removed from the sample database from which subsequent interview samples will be drawn. When contact is made with another individual who knows the participant well, such as a family member, social worker, or guardian, the interviewer offers that person the option of completing the survey on the participant's behalf, or helping the participant complete the survey if the participant is unable to complete the survey independently.

After all calls have been made on a monthly sample, a second mailing is sent to each participant on the list for whom the response outcome was "No Contact," those who are not home or do not answer the telephone, or "No Listing," those participants for whom there is no valid telephone number. This mailing includes another copy of the survey, a postage-paid envelope, and a letter inviting the participant to complete and return the survey, or call TMG to arrange a time to complete the survey over the telephone. The cumulative return rate for this follow-up mailing is 21%.

Cumulative Response Rate

In July 2001 the protocol for drawing the sample was revised when project staff obtained access to the CARES system, which provided a more reliable source for contact information. Through CARES, the project is able to obtain telephone numbers for almost 100% of the sample. Although access to the CARES database has increased the availability of telephone contact numbers, many of the CARES-generated numbers are also incorrect or inactivated. However, the No Listing rate has decreased during the year ending June 30, 2003. The cumulative rate of sample participants without a valid listing has decreased from 28% on June 30, 2002, to 19% as of June 30, 2003. (Note: for the year ending June 30, 2003, that rate was 14%)

The inability to make a voice contact with sample participants continues to be an obstacle to obtaining completed surveys, accounting for approximately 37% of sample participants. This figure is an improvement; however, from the period ending June 30, 2002. At that time, 43% of sample participants resulted in failure to make a voice contact. This includes all "No Contacts" and "No Listings."

As of June 30, 2003, the following progress had been made on the administration of the Initial and Follow-up Surveys. One thousand three hundred twenty two (1,322) Initial Surveys and 2,753 Follow-up Surveys have been mailed. The table below summarizes the cumulative response rates where all contact attempts have been exhausted for each survey.

Cumulative MAPP Survey Response Rates - April 1, 2001 through June 30, 2003

Response	**Initial Survey Percentage** (N=1322)	**6-Month Follow-Up Survey Percentage** (N=1373)	**12-Month Follow-Up Survey Percentage** (N=869)	**24-Month Follow-Up Survey Percentage** (N=511)	Combined Percentage
Survey Completed	31%	29%	29%	29%	30%
Refused*	32%	34%	34%	30%	33%
No Telephone Listing	23%	21%	14%	11%	19%
No Contact (5 attempts)	14%	15%	22%	29%	18%

*** "Refused" includes participants who declined to participate in the survey, and participants who told the interviewer they would mail in the survey, but failed to do so.**

Source: The Management Group (TMG). These figures do not include surveys returned to APS; therefore, actual response rates are slightly higher.

The cumulative rate for participants who explicitly decline to participate in the survey is 19% across all surveys (18% for Initial Surveys, 20% for all Follow-up Surveys). Another 14% promised to complete and mail in a written survey, but failed to do so. Of those who explicitly decline to participate, the most common reasons given include variations of "I don't have time," and "I don't know what the MAPP program is."

Survey staff also field frequent requests for additional information about MAPP. These requests are always referred to an appropriate source, including the statewide toll-free telephone number and the name and number of the participant's local economic support office.

Findings

Initial and Six Month Follow-Up Surveys were mailed from April 2001 through March 2003. During this 24 month period, 1,322 Initial and 1,373 Six Month Follow-Up Surveys were mailed. Returns were accepted through June 30, 2003, resulting in 464 Initial and 450 Six Month Follow-Up completed surveys. These figures constitute overall response rates of 35% and 33%, respectively. These response rates are slightly higher than the completed survey figures listed in the chart on the previous page, because they include surveys sent directly to APS, which were not originally counted as completes by TMG.

The Initial and Follow-Up Surveys include questions on the following:

- basic demographics,
- recipient understanding of the program,
- financial status/work experience,
- physical and mental health/level of functioning,
- quality of health care, and
- satisfaction with the program.

Where possible, the analysis compares the results from the Initial and Follow-Up Surveys to identify changes over time. However, the results do not represent longitudinal findings for the same group of participants over time; rather, the results are a general indication of recipient responses at enrollment and after 6 months of enrollment.[19]

Demographics

Gender is split nearly 50/50 among both the initial and follow-up survey respondents, with female respondents accounting for just over 50% of all respondents for both surveys. Respondents to both surveys are predominantly Caucasian (87% - initial, 88%- follow-up).[20] The average age of the respondents was 49 years. Average monthly earned income for the initial respondents is $306.51, while follow-up respondents report average monthly income of $269.69, a difference of $36.82.[21] Both averages are reasonably close to the overall MAPP average of $290. Over 59% of initial and 62% of follow-up respondents live in their own home or apartment, with 24% and 26% living in someone else's home or apartment, respectively. Most MAPP participants are single. Over 78% of the initial and 81% of the follow-up respondents report being single. Almost 75% of the initial respondents have at least a high school education. Education was not asked of follow-up survey participants.

[19] 86 individuals responded to both the Initial and the Six Month Follow-Up Surveys, or 18.5% of the Initial respondents and 19% of the Six Month Follow-Up respondents. A small number of useable completed surveys were unidentifiable; therefore, the actual number of respondents who completed both surveys maybe slightly higher.

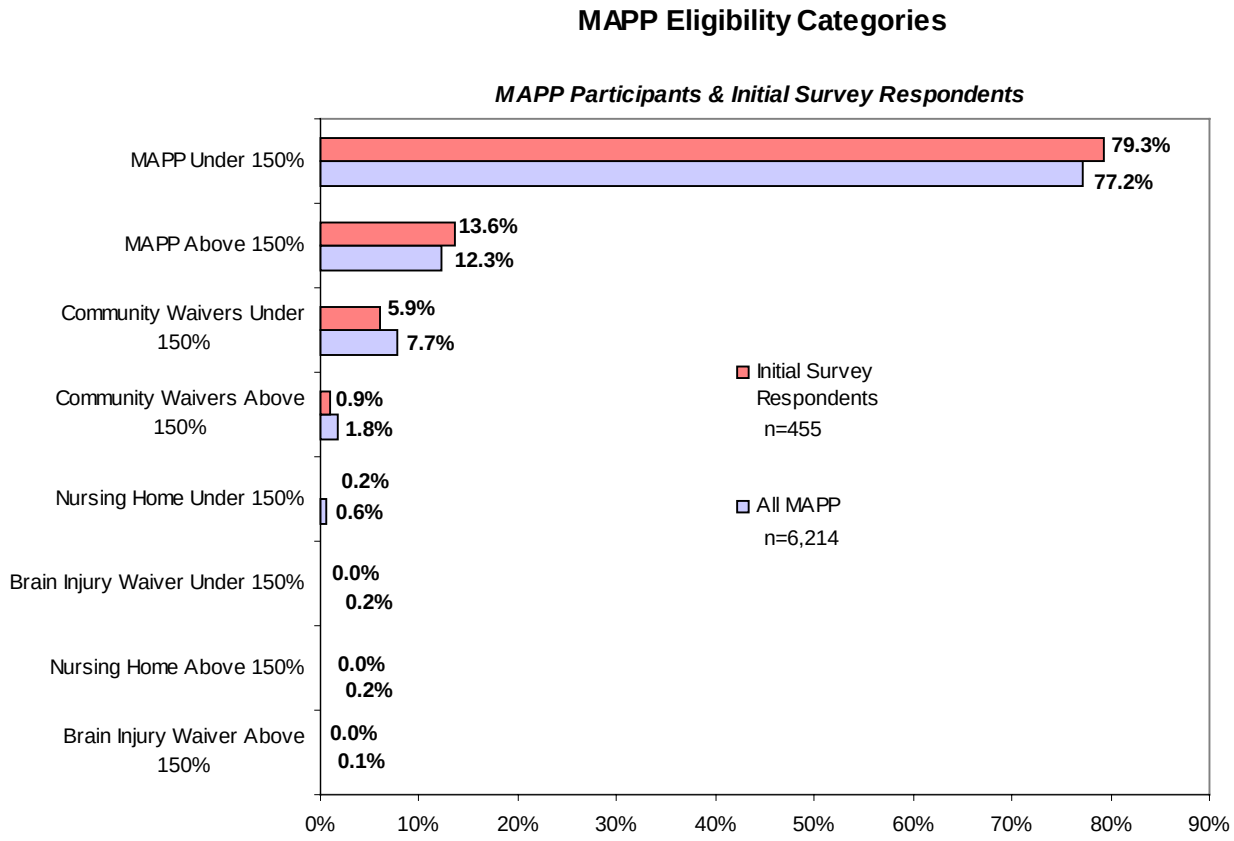
[20] Race was not identified on the follow-up surveys; therefore, the race figures cited here are from the MEDS data warehouse (general Medicaid data) where respondents could be identified.

[21] Monthly earned income data was taken from CARES for all survey respondents who could be matched with the CARES data set. Income data was obtained for 433 initial and 424 follow-up respondents using their most recent monthly income figure available through CARES.

In general, the initial and follow-up respondents are very similar on basic demographic criteria, such as gender, age, and race. More importantly, each survey sample is representative of the larger MAPP population on most demographic indicators. Seven demographic indicators were tested for significant differences between the initial and follow-up respondents and all individuals who have ever been enrolled in MAPP. The seven indicators are:

1. Gender
2. Race
3. Income
4. Medical Status Codes
5. Family Size
6. Percentage above/below the Federal Poverty Level (FPL)
7. Rural-Urban Commuting Areas (RUCA)

Among initial respondents, only medical status codes differed significantly from the overall MAPP population. Although significantly different at the 95% confidence level, the distribution of medical status codes among initial survey respondents and the MAPP population are very similar. The graph below shows the distribution of medical status codes for each group.



Source: Medicaid administrative data through the MEDS data warehouse.

Follow-up respondents differed from the overall MAPP population only on race. The follow-up respondent group was more homogenous than the MAPP population; however, the distribution

of races remained very similar. The table below shows the racial distribution for both surveys and the entire MAPP population.

Race *MAPP Participants & Survey Respondents*			
	MAPP	**Initial**	**6M***
Caucasian	84.44%	87.03%	87.98%
Unknown	8.66%	8.13%	6.35%
African American	4.46%	2.20%	4.08%
Hispanic/Latino	0.79%	0.88%	0.68%
Hispanic/Latino & Other	0.80%	0.66%	0.68%
American Indian	0.51%	0.22%	0.23%
Asian	0.16%	0.22%	0.00%
Multiple-Not Hispanic/Latino	0.16%	0.66%	0.00%
Native Hawaiian	0.02%	0.00%	0.00%
Total	**100.00%**	**100.00%**	**100.00%**
N:	**6,214**	**455**	**441**
* Significantly different from all MAPP participants at the 95% confidence level.			

On all other demographic indicators, as listed above, there are no other significant differences between the initial and follow-up respondents and the general MAPP population.

Understanding of MAPP

Outreach has been identified as a challenge since program inception, and the survey results confirm this. Anecdotal evidence from the interviewers at TMG, as well as the evaluation team indicates a broad lack of knowledge regarding MAPP. One of the most distressing findings in this regard is that most survey participants did not know that they were enrolled in MAPP, most likely because their county worker switched them from regular Medicaid to MAPP without notifying them of the change. This scenario appears to be quite common for MAPP participants with previous Medicaid experience. Because the benefit packages for MAPP and regular Medicaid are generally very similar, there is little impetus to inform the participant of the change to MAPP. As noted by the interviewers at TMG, "A number of respondents do not recognize the MAPP name or know how or when they entered the program. This continues to be the most common response [to the survey phone calls]. They know they have Medicaid (or a Forward card), but do not understand that they are accessing it through a program called MAPP." However, TMG noted that respondents who do understand MAPP often "express explicit gratitude for the program, most frequently citing the cost of medications that they would not otherwise be able to afford."

More specifically, respondents to both the initial and follow-up surveys indicate a limited understanding of the MAPP eligibility criteria, benefit structure, and available resources. Most importantly, many of the survey participants are not aware of the work requirement associated with MAPP. According to TMG, "Many claim to not know about the work requirement (particularly elderly individuals, who are often worried when they see or hear these questions about work). Some respondents do not recognize that they may indeed be doing "work" according to program definition. For example, after answering "no" to a question about work,

some respondents later describe some activity that may actually qualify as work, like sewing, doing yard work or maintenance in exchange for a rent subsidy or other non-cash payment." This finding has wide reaching ramifications for MAPP. The intent of MAPP is to provide people with disabilities who are working or would like to work, with an opportunity to work more, save more and receive the same benefits from work that are available to the non-disabled population, without fear of losing their health benefits. The fact that many survey respondents are unaware of the work requirement calls into question the make-up of the current MAPP population. The original target population for MAPP was the disabled population who was, or could have been, engaged in "substantial" work. With few survey respondents aware of the work requirement, it is doubtful that a substantial number of program participants are engaged in substantial work activities.[22]

An attempt was made to quantify the number of survey participants who did not recognize the MAPP program, and who did not know that they were enrolled in such a program by adding two additional questions to both surveys. However, there was not enough time prior to final data collection to collect enough responses to be representative of all returns.

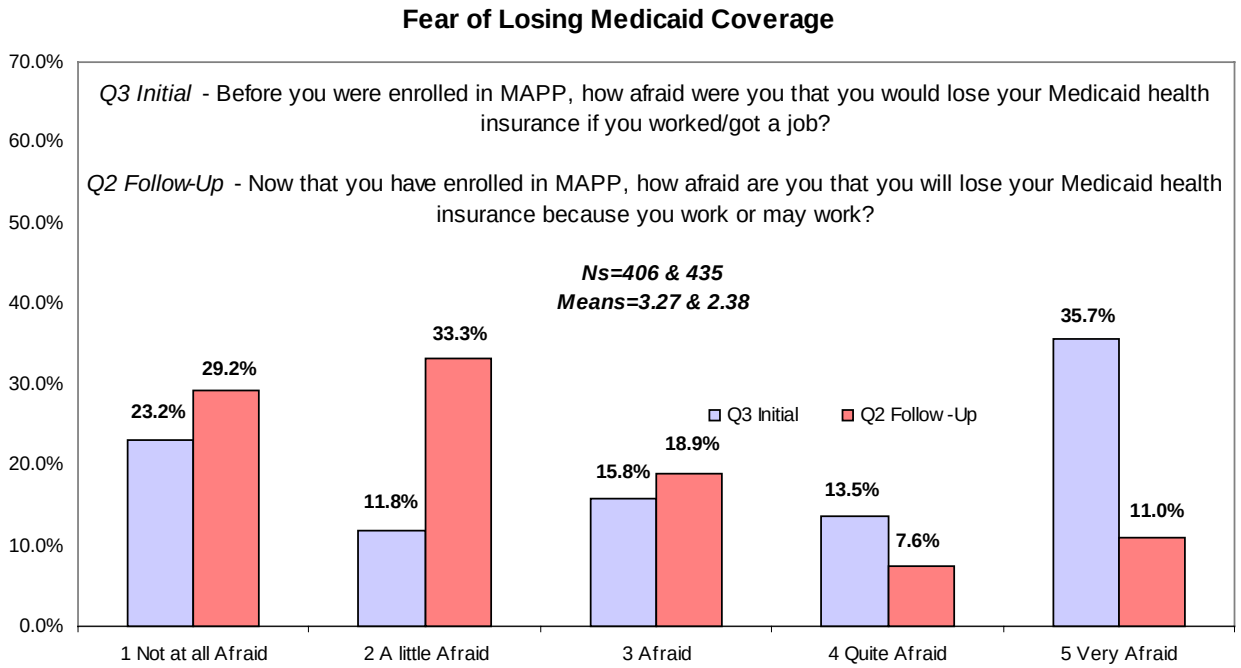
Although the anecdotal evidence suggests that very few survey respondents have a strong understanding of MAPP, the actual survey responses show a slightly better understanding of the program. However, TMG also noted, "Some participants in the above category [those who know little about MAPP] react with fear or concern about losing their health insurance – they complain about the intrusion of the survey, claim not to understand what MAPP is, but answer anyway because they fear losing their Medicaid if they do not." Because of the fear of losing their health benefits, it is possible that survey respondents may be inclined to provide more positive responses to all survey questions. Fear of losing health insurance is discussed in the following section of the report, and should be kept in mind when interpreting the survey findings.

Fear of Losing Health Care Coverage

MAPP was developed, in part, to address the fact that individuals with disabilities are not able to work as much as they would like because increased earned income would cause them to lose their Medicaid health care coverage. Therefore, Initial Survey respondents were asked, prior to their enrollment in MAPP, how afraid were they that they would lose their MA coverage if they began working. Prior to MAPP enrollment, over 77% of respondents were at least "a little afraid" of losing their Medicaid coverage if they began working.

This fear appears to diminish over time. While 77% of initial respondents were afraid, only 71% of follow-up respondents fear losing health care coverage. The chart below illustrates that the fear of losing health care benefits due to work lessens with experience in MAPP.

[22] The issue of work, and the notion of "substantial work," will be discussed in more detail later in the analysis. To further address the issue of the original MAPP target population, several survey findings were analyzed relative to earned income reported in CARES.



Financial Status/Work Experience

When asked to identify their sources of income, 85% of respondents to the Initial and Follow-Up Surveys indicated that they had income from a job or income from disability payments. Among both groups of respondents, disability payments accounted for 43% of all sources of income and income from a job accounted for an additional 42%, suggesting that workers with disabilities still depend heavily on their disability benefits for support[23]. This pattern holds true for follow-up respondents as well.

When asked how much they were able to save in the previous 6 months, the majority of initial and follow-up respondents had saved nothing. Only 29% of initial respondents were able to save during the previous six months, whereas, 37% of the follow-up respondents were able to save. On average, initial respondents have been able to save $159, while follow-up respondents averaged $339, a significant increase.[24] This finding suggests that MAPP is currently meeting its goal of helping program participants save while enrolled in the program.

However, this population is still falling short of its savings goals. Of those initial and follow-up respondents who did save during the previous six months, only 19% and 28% respectively, reported saving over $100. Almost 58% of initial respondents indicated that they could not "afford the things they needed." Fifty-nine percent of the follow-up respondents also could not afford the things they needed.

[23] The remaining 15% of income comes from investments, support from family/friends, other government assistance or "other" sources.

[24] Only 360 of the 464 initial respondents provided a savings total, and 403 of the 450 follow-up respondents provided this information. The averages cited above include all respondents who reported any savings or indicated $0 savings.

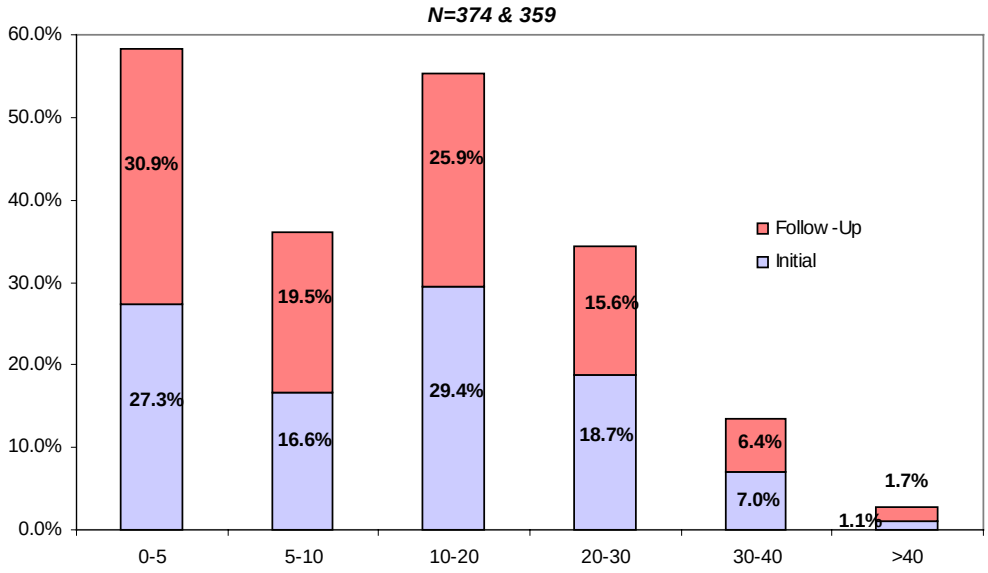
Given responses to questions about how the new opportunity to save has changed their thinking about the future, the survey suggests that saving among MAPP participants is less an issue of opportunity than an issue of ability. Most MAPP participants do not appear to have the available resources to begin saving at a significant level, although MAPP is helping people save more than was possible without the program's benefits.

Respondents to both surveys were asked how much they have spent on "independence related" items/services in the past year. Only 249 initial and 279 follow-up respondents reported valid figures for this question, averaging $1,837 and $1,037, respectively. Almost 32% of follow-up respondents who provided feedback on independence related items spent $0 on these items, whereas, only 14% of initial respondents spent $0 on independence related items/services. Although this difference is not significant, the reduction in spending for independence related items suggests that MAPP may be providing items/services that individuals had to purchase on their own prior to enrollment.

Follow-up respondents were asked to identify the type of independence items they purchased in the previous six month period. Twenty-three percent of the items listed were medications/health related equipment or expenses. This finding may call into question the hypothesis that MAPP is now covering items that were previously purchased out-of-pocket by the participant. However, "health related equipment" encompasses a variety of independence items, many of which may not be covered by MAPP. In addition, transportation related items, which are not covered by MAPP, accounted for an additional 21% of the spending.

Respondents were asked how many hours they work in a typical week. Only 7% of initial and 6% of follow-up respondents worked between 30 and 40 hours per week, with less than 2% working more than 40 hours. Fewer than 20% of the follow-up respondents reported 5-10 hours of work per week, as compared to just under 17% of the initial respondents. Based solely on this indicator, it is very difficult to determine if the follow-up respondents are working more than the initial respondents, as expected. Complete results are provided in the following chart.

How many hours do you work in a typical week?



Almost all of those who report working are receiving money as compensation. This finding was unexpected. It had been thought that the high numbers of individuals reporting very low monthly incomes were receiving in-kind compensation in addition to or in place of monetary compensation. However, only 5% of initial and 7% of follow-up respondents report receiving in-kind compensation as their sole source of income, and only 4% of initial and follow-up respondents report receiving both money and in-kind compensation.[25] These findings suggest that even participants receiving less than $100 per month in income are typically not receiving in-kind compensation.

The majority of initial (79%) and follow-up (80%) respondents reported earning $8.00 per hour or less.[26] The average hourly wage reported by initial respondents was $8.30, as compared to $6.65 for the follow-up respondents. It was expected that the follow-up respondents would have higher hourly wages than the initial respondents based on their extended experience with MAPP. Although the initial respondents report earning higher wages, the difference in hourly wages is not statistically significant. However, this finding does not help to explain why the follow-up respondents are not earning more than the initial respondents.

Respondents to both surveys also reported their earnings from the previous month, 245 initial respondents averaged $381 in earned income in the previous month before the survey was administered, while 215 follow-up respondents averaged $337. The entire MAPP population, as identified in CARES, averages $290 per month. Although these averages differ, they are not statistically different, indicating that the survey data and the CARES data are most likely valid indicators of MAPP participant income.

Follow-up respondents did report earning more, on average, in the past year than the initial respondents. Follow-up respondents averaged $3,428 of income from employment in the previous year, whereas initial respondents averaged $3,299.[27] This finding fits with the objectives of the MAPP program; however, this difference is also not significant. Given these findings, it does not appear that MAPP is helping people earn more through employment; however, given that over 50% of the initial and follow-up respondents did not report working, these findings would require additional follow-up and analysis before definitive conclusions could be drawn.

Only 20% of the initial and 19% of the follow-up respondents stated that they are self-employed.[28] Of those respondents who reported being employed by someone else, most (60% - initial, 55% - follow-up) were employed by for profit businesses. Private non-profit businesses and sheltered employment were the second and third most common employers, respectively.

[25] Since knowing very little about MAPP was identified as a reason for refusing to participate in the survey, it's probable that the survey sample has lost some of the $0/in-kind workers.

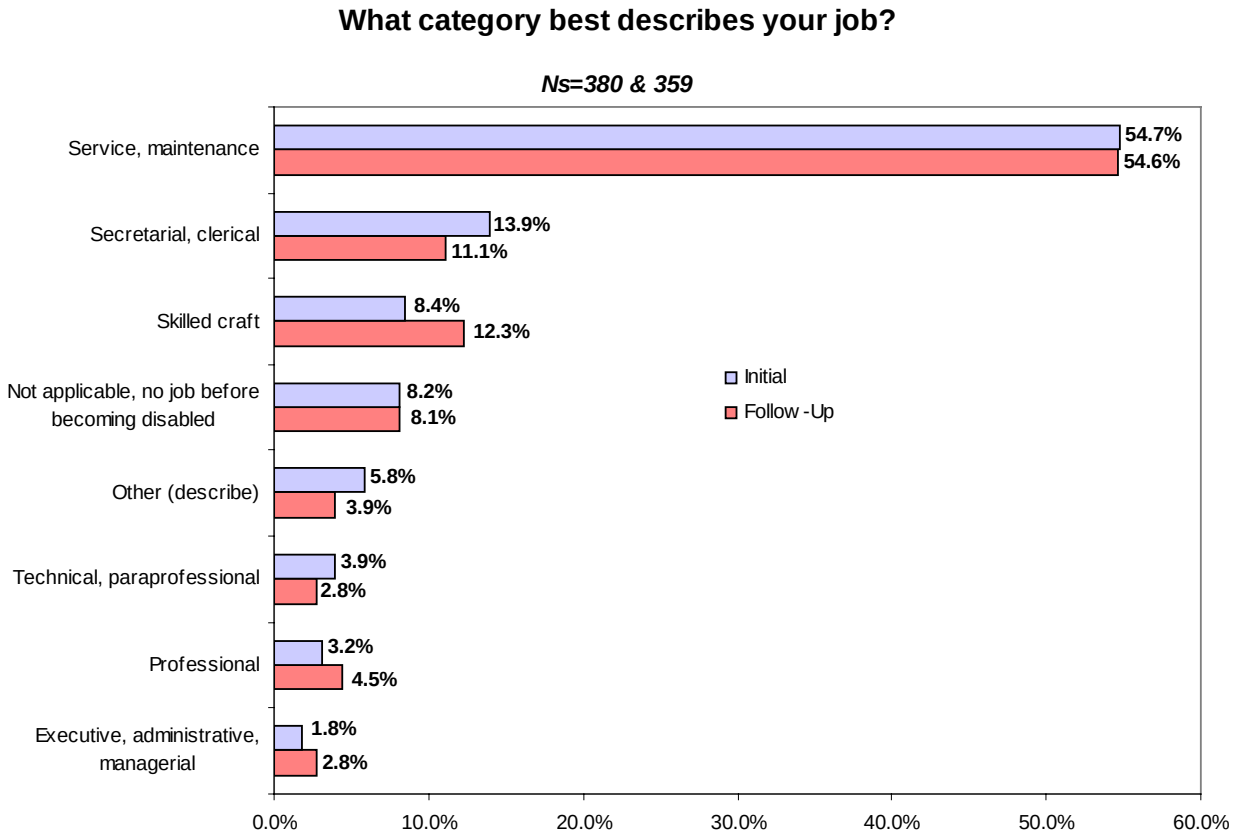
[26] All questions regarding earnings were first filtered by a previous question asking about employment and also by the type of compensation received for employment. The filters reduced the number of valid responses regarding hourly wages to 272 initial respondents and 240 follow-up respondents.

[27] This question was also filtered by previous questions on employment and compensation; therefore, the final number of respondents reporting annual income was reduced to 211 initial respondents and 179 follow-up respondents.

[28] These figures represent a subset of the survey respondents who previously indicated that they had income from a job.

Over 85% of the follow-up respondents have been with their current employer for over six months, whereas only 72% of the initial respondents have been with their current employer for over 6 months. This finding suggests that MAPP does improve employment stability among program participants.

Just under 55% of the initial and follow-up respondents described their jobs as service/maintenance related. Secretarial/clerical (14%) was the second most common job category among initial respondents, followed by skilled crafts (8%). Over 12% of follow-up respondents categorized their job as a skilled craft, followed by secretarial/clerical (11%). Although the follow-up respondents reported more skilled craft positions and slightly more professional positions than did initial respondents, the data do not suggest that MAPP has helped program participants find and maintain more skilled positions.



Beginning with job satisfaction, several employment related questions were asked of the initial and follow-up respondents, specifically focusing on barriers to employment and experiences with HEC. Over 79% of initial and follow-up respondents report being satisfied or very satisfied with their present job. Interestingly, job satisfaction is not correlated with reported earned income.

Initial respondents were provided a list of work barriers and asked to identify all barriers that they had experienced. Poor mental or emotional health was the most common barrier cited by initial respondents (15% of all barriers listed) along with physical limitations (15%), and fear of losing health insurance (14%). Complete results can be found in the table on the following page.

Over 37% of initial and 33% of follow-up respondents reported that they wanted to work more hours. Barriers to working more hours were identified by 57% of the initial respondents and 44% of the follow-up respondents. As above, the majority of these respondents cited poor health as preventing them from working more hours. In addition, almost 27% of initial respondents also indicated that they had "no opportunity to do so (work)," whereas only 16% of the follow-up respondents reported having "no opportunity" to work. These finding suggests that over time MAPP is providing an opportunity to work for some individuals who previously could not.

Barriers to Work
Initial Survey Respondents

Physical limitations	181	14.7%
Poor mental/emotional health	181	14.7%
Fear of losing health insurance	171	13.9%
Frequent illness/hospitalization	105	8.5%
Lack of job training	94	7.6%
Lack of job experience	87	7.1%
Lack of skills	76	6.2%
Lack of transportation	72	5.8%
Employer discriminatory attitude	66	5.4%
Lack of employer flexibility	63	5.1%
Can't take time off for health	41	3.3%
Lack of job interviewing training	38	3.1%
Lack of support from co-workers	28	2.3%
Lack of appropriate clothing	17	1.4%
Other	8	0.6%
Lack of childcare	4	0.3%
Total	**1232**	**100.0%**

As a follow-up to the listing of barriers to work, initial respondents were also asked to rate the importance of the "fear of losing your Medicaid health insurance" as a barrier to work. Eighty-two percent of initial respondents indicated that the fear of losing their Medicaid health insurance was at least "an important barrier" to work. This finding illustrates the need for MAPP to create an opportunity for people with disabilities to work without losing health care coverage through Medicaid. However, the fact that poor health and physical limitations are ranked above the fear of losing health coverage suggests that it may take more than MAPP to fully support people with disabilities who want to work.

Respondents to both surveys were asked if private health insurance through their employers had become more accessible after enrolling in MAPP. Very few respondents (8% initial and 6% follow-up) indicated that private insurance had become more accessible since their enrollment in the program. This is consistent with findings related to HIPP, where very few MAPP participants are also participating in the HIPP program.

A fair number of respondents (33% initial and 28% follow-up) are looking for more challenging jobs, or want to change jobs (16% initial and 28% follow-up). The fact that such a larger percentage of follow-up respondents would like to change jobs may be related to a reduced fear

of losing health coverage now that they have extended experience with the program. Many of these respondents are looking for higher pay. Of those who wanted to change jobs, 22% of the initial and 19% of the follow-up respondents were in search of higher wages. With reduced fear of losing health coverage, MAPP participants have more freedom to earn higher wages.

Follow-up respondents were also queried about their experiences with HEC and how those experiences have assisted them with employment. While only 66 respondents reported having experience with HEC, these individuals appear to be satisfied with this aspect of the program. The vast majority, 91%, felt that their HEC counselor had been helpful. Only 47 initial respondents and 77 follow-up respondents stated that they have an employment plan, either through HEC, another vocational provider or on their own. Among this group of respondents, 51% of the initial and 64% of the follow-up respondents were at least satisfied with the progress that they had made under their employment plan. Follow-up respondents were significantly more satisfied than the initial respondents with the progress that they had made under their employment plan, which one would expect since it takes time to make progress on their goals. This suggests that with time, MAPP/HEC is helping some individuals achieve their employment goals.

Only 42% of respondents to either survey indicated that they receive income from a job. Very few respondents work over 30 hours per week, but most of the workers are receiving money as compensation, as opposed to in-kind goods and services. Follow-up respondents averaged more earned income in the past year than initial respondents, but not significantly more. Approximately 20% of all respondents reported being self-employed. Over 85% of the follow-up respondents versus 72% of the initial respondents had been with their companies for over six months. Three major barriers to work were identified by survey respondents: physical limitations, mental/emotional health and fear of losing health insurance. These findings suggest that a fear of losing health insurance is not the only important barrier to work for individuals with disabilities.

Twenty-nine percent of initial and 37% of follow-up respondents were able to save in the previous six months. Follow-up respondents have been able to save significantly more than initial respondents, possibly due to their enrollment in MAPP. Approximately half of the initial and follow-up respondents indicated that they have purchased independence related items or services in the past year. Follow-up respondents spent less than their initial counterparts on these items, indicating that MAPP may be providing some of the services previously purchased out-of-pocket.

Physical and Emotional Health/Level of Functioning

In general, most survey respondents report being in good or fair health. Eighty-three percent of the initial and follow-up respondents rated their health as at least fair. Few respondents (13%) to either survey rated their health as very good or excellent. There is no significant difference between the initial and follow-up respondent based on perceived health status; however, earned income is positively correlated with one's reported health status. On average, higher income earners report being healthier than lower income earners, supporting the previous findings regarding poor physical and emotional health as barriers to employment.

Several survey questions were included to assess recipient level of functioning and level of assistance received from friends and family members. Approximately one-third of all survey respondents stated that they need no physical help and support from others for day-to-day activities. Both the initial and follow-up respondents require similar amounts of physical help and support. Of potential greater interest, initial and follow-up respondents who report higher monthly incomes tend to require less physical help and support from others. Again, this finding provides evidence that earned income may be of use as a proxy for level of functioning and level of employment. As stated earlier, it is suspected that MAPP may be more effective for participants who are capable of engaging in substantial work activity.

A larger percentage of respondents require emotional help than require physical help. Thirty percent of initial and 36% of follow-up respondents require "a little" emotional help and support from **others**. Thirty-two percent of the initial respondents need "quite a bit" or "a great deal" of emotional support from others. This drops down slightly for follow-up respondents to 25%; however, on average, both respondent groups require similar amounts of emotional support.

Thirty-two percent of both respondent groups receive "quite a bit" of physical and emotional support for day-to-day activities from **family or friends**, while over 32% of initial and 29% of follow-up respondents also receive "quite a bit" of physical and emotional support from medical workers. The initial and follow-up respondents receive approximately the same levels of physical and emotional support indicating that after six months of enrollment in MAPP, the program has not reduced the level of supports needed by participants.

The majority of initial (61%) and follow-up (63%) respondent are limited at least "a little" by their health during moderate activities. Forty-eight percent of initial respondents and 50% of follow-up respondents report that their physical or emotional health has interfered with their social activities "a little of the time" or "some of the time" during the past four weeks. Approximately 30% of the initial and 26% of the follow-up respondents reported that their health stops them from "getting around" either "quite a lot" or "very much." Health also limited the respondents' leisure activities. Fifty-one percent of the initial respondents reported being limited by health during leisure activities "quite a lot" or more, compared to 45% of follow-up respondents.

These health status indicators appear to represent a disabled population capable of work; however, the employment and income figures discussed previously seem to indicate that the current MAPP population skews toward people with disabilities who work, but who have severe impairments. Based solely on these data, it is difficult to assess the functional status of the general MAPP population. Continuous efforts are underway to obtain data regarding primary disabling conditions or to develop an accurate measurement tool to determine a participant's disability and/or functional status. This information could be used to target specific disabled populations where MAPP could be most effective, and address issues with MAPP that would make it more effective for people with more serious limitations who want to work.

Quality of Health Care

MAPP participants were also asked to rate their health care providers. Beginning with the "health care provider who knows (them) best[29]," respondents were asked to rate that provider on a scale from "0-worst health care provider possible" to "10-best health care provider possible." MAPP participants seem very satisfied with their primary providers. Primary health care providers averaged a score of 8.31 among initial respondents and 8.30 among follow-up respondents. Wisconsin Medicaid fee-for-service (FFS) respondents to the 2002 Consumer Assessment of Health Plans (CAHPS) survey rated their personal doctors an average of 8.72 on the same eleven point scale[30]. Less than 3% of initial or follow-up respondents rated their primary health care provider a 3 or lower. Results were very similar for care provided by others besides the participants' personal doctors or nurses. The average rating of care given by providers other than a personal doctor or nurse was 7.9 among both respondent groups. **ALL** health care was rated similarly among both groups of respondents, as well. Initial and follow-up respondents rated their overall health care an average of 8.13 and 8.05, respectively. Among CAHPS FFS respondents, all health care providers averaged 8.5, slightly higher than the average rating provided by the MAPP participants. Comparisons between the initial and follow-up respondents on these indicators show no statistical differences in their ratings of health care.[31]

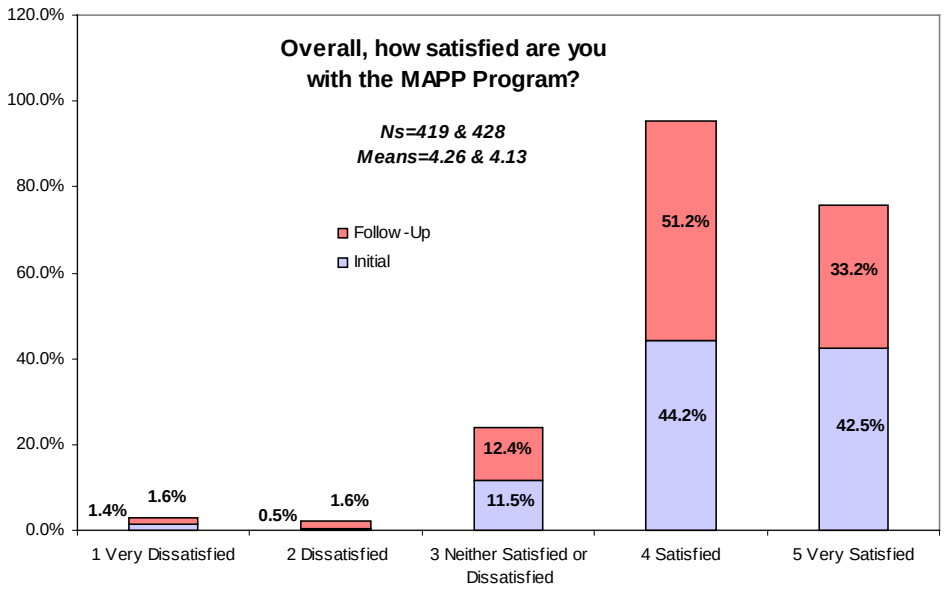
Overall Program Satisfaction

The majority of survey respondents report being satisfied with the MAPP program. Eighty-seven percent of initial and 84% of follow-up respondents were either satisfied or very satisfied with MAPP. Although both groups of respondents were generally satisfied with MAPP, follow-up respondents were less satisfied with the program. Ninety-six percent of initial and follow-up respondents would recommend MAPP to other people with disabilities.

[29] The health care provider could be a general doctor, a special doctor, a nurse practitioner or a physician assistant.

[30] These findings were obtained from internal Department of Health Care Financing reporting on the 2002 CAHPS survey. The CAHPS FFS population is a similar, but not identical, comparison group in relation to the MAPP population. Commercial purchasers of insurance tend to rate their providers lower yet, possibly based on higher expectation of care, and given that the MAPP population is a working disabled population fitting somewhere between the average commercial and Medicaid populations, one would expect their ratings to be slightly lower than the Medicaid population as a whole.

[31] When interpreting these questions, please note the following comment from the TMG interviewers: "Question about quality of health care from other health care professionals is often difficult for respondents to answer. They often want to rank other providers individually, not give a collective ranking. They tend to have very individual feelings about these people, who often include one or more people coming into their homes."



Given the large number of respondents who report not knowing that they are enrolled in MAPP, or having limited knowledge of the program, it is possible that many respondents were actually considering their general Medicaid benefits asked about satisfaction with MAPP. In either case, respondents are very satisfied with their services.

Disenrollment Survey

In conjunction with the initial and follow-up surveys, the evaluators have also administered a survey to better understand program disenrollments. The survey examines the participants' decision to disenroll, as well as the effectiveness of MAPP in allowing the participants to maintain their health coverage while working and save while enrolled. The survey also addresses general satisfaction with MAPP during enrollment.

These results are preliminary as data collection will not be completed until fall 2003. Disenrollment surveys are distributed quarterly. As of February 2003, 462 disenrollment surveys had been mailed to former program participants. Current results include 106 surveys completed through June 2003, representing a response rate of 23%. This rate is respectable considering that respondents are no longer participating in the program and have little incentive to complete the survey. The response rate is also affected by the fact that a number of disenrollments result from deaths among program participants.

Disenrollment Survey respondents are 51% female, predominantly Caucasian (80%) and average 49 years of age, very similar to the Recipient survey respondents and the general MAPP population. Disenrollment respondents generally have smaller families than the general MAPP population; however, both groups average just over one household member. Disenrollment respondents also reported significantly higher average monthly earned income ($415)[32], than the general MAPP population ($290/month). Some of the disenrollment respondents are earning more than 250% FPL, which would explain their disenrollment and drive-up the average

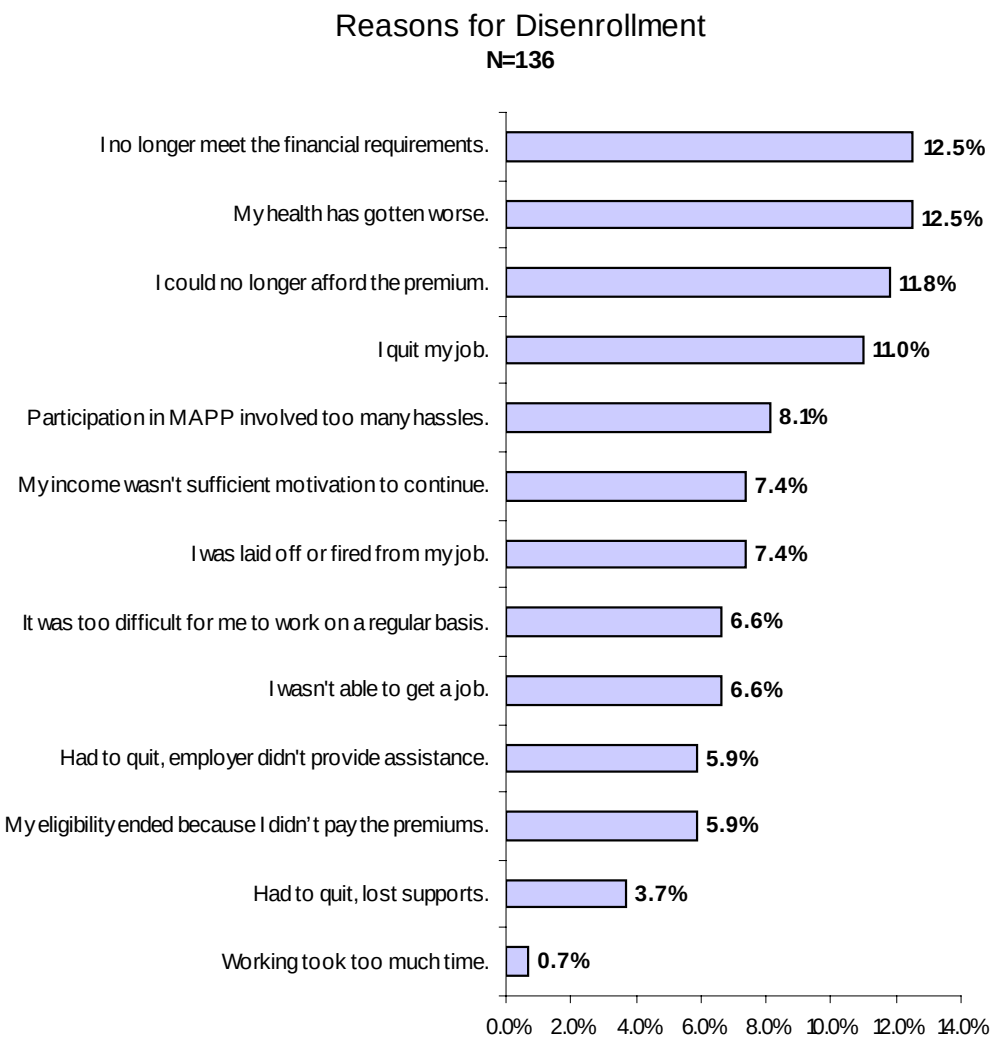
[32] 55 Disenrollment Survey respondents were matched with CARES earned income data, utilizing the earned latest earned income figure available.

monthly income of the group. However, the average of $415 per month also matches well with the original MAPP target group population who is capable of substantial work, which suggests that many participants may be disenrolling from the program for other reasons.

The majority (78%) of respondents disenrolled from MAPP because they were no longer eligible for the program. Disenrollees who did not lose eligibility were asked if they could have continued in the program but chose not to (15%), or if they could have continued but decided, with the help of MAPP staff, to disenroll (7%). Six percent of the respondents agreed with staff that they should disenroll, although they could have continued their eligibility. Without direct follow-up, it is difficult to speculate on the circumstances that would result in such a disenrollment.

Respondents were provided 13 potential reasons for disenrollment and asked to identify **all** that applied[33]. The most common reason for disenrollment was that the respondents no longer met the financial requirements of the program. Detailed results can be found in the following chart.

[33] 69 Disenrollment Survey respondents identified 136 reasons for disenrollment using the 13 reasons provided in the survey.



In addition to the disenrollment options listed on the survey, respondents also had an opportunity to identify other reasons for disenrollment. Forty-nine disenrollees provided additional reasons for their disenrollment, ranging from "I married in September and was eligible for a program without a premium," to "I have only a part-time job and have a high rent to pay, and a car payment. It was hard to come up with the money to pay MAPP." Other reasons for disenrollment included moving out of state, temporary/seasonal employment, and case worker turnover (missed renewal period). Several respondents indicated that their premiums were prohibitive. One respondent stated, "I found out that my IRWEs were not allowed as my vocational support is paid by my benefits and is not paid directly out of my pocket. So I ended up with a $350 per month premium, which is way too expensive for me to be able to continue participation in the program." While the majority of reasons for disenrollment were related to employment issues, a number of other issues were also cited.

The majority of MAPP participants, 90%, felt that MAPP met their expectations for retaining their health insurance. Reasons for MAPP not meeting expectations ranged from a participant having to pay $300 per month to stay enrolled to another recipient who felt that he received no

follow-up help after enrollment. One participant reported having a bad working relationship with MAPP staff and another did not know that they had been enrolled in MAPP. In addition, one respondent noted that, "The entire T-19 program is difficult to understand and therefore comply with."

Well over half of the MAPP participants, 65%, were able to meet their expectations of saving while they worked. MAPP participants that were not able to save while on MAPP cited low wages as the primary reason for not saving. In addition, several respondents noted that their bills exhausted their monthly income. Other participants stated that premiums were too high, which inhibited their efforts to save.

The disenrollment survey also measured satisfaction with the program. Overall, former participants were satisfied (40%) or very satisfied (37%) with MAPP. However, 11% were very dissatisfied with the program. These findings suggest that MAPP is generally meeting the needs of most participants, yet some program issues remain unresolved. When asked if they would re-enroll in MAPP given the chance, 85% indicated that they would, while 15% would not[34]. These findings support the previous findings of overall satisfaction with the program from the Recipient surveys.

Lastly, respondents were asked to comment on changes to MAPP that could improve the program. Respondents typically reported that premiums were too high, income and asset caps were too restrictive, there was difficulty with coordinating benefits, and the basic eligibility requirements of the program were not well understood. One respondent noted that there was a significant lack of coordination between his health care provider, his county worker and the state, which resulted in loss of benefits and general frustration among everyone involved. While MAPP provides access to health care services, it does not necessarily provide supportive services such as coordination of care.

Based on this feedback and similar feedback from other sources, it appears that there may be a need for more formal coordination of services. One respondent felt strongly that MAPP would work very well as a work incentive program if it had dedicated staff within a separate unit of the broader Medicaid program. This emphasizes the need for coordination of services and better outreach to people with disabilities who are working.

[34] Only 80 of the 106 respondents answered this question.

V. Fiscal Evaluation

Purpose

The purpose of the fiscal evaluation is to describe the effect of MAPP program participation on State and Federal Medicaid spending for health care services. The previous two *MAPP Evaluation Annual Reports* described data on Medicaid health care expenditures for MAPP program participants and comparable SSI or adults with disabilities who are not enrolled in MAPP. This analysis describes MAPP health care expenditures compared to expenditures for non-MAPP participants over the first three years of MAPP program operation.

This analysis also examines differences in utilization and expenditure between MAPP participants who earn higher incomes and those with low, or no income. A major goal of MAPP is to provide low-cost health insurance to workers with disabilities whose earnings are too high to qualify for regular Medicaid, but who otherwise do not have insurance coverage. Therefore, this fiscal evaluation highlights the group of MAPP participants with substantial earned income.

Data

Data for this fiscal analysis come primarily from paid claims stored in the Medicaid Evaluation and Decision-Support (MEDS) subsystem of the Medicaid fiscal agent's Management Information System. These data are described more fully in the MAPP 2001 Annual Report. Additional data on participants' earnings were obtained from the State's Client Assistance for Re-employment and Economic Support (CARES) system.

The CARES system maintains gross earned income per month for MAPP participants. Using the most recent month of reported earned income through June 2003[35], each MAPP participant was classified as a high or low wage earner. The Social Security Administration's (SSA) substantial gainful activity (SGA) level for 2003 of $800 per month was adopted as the threshold for classification as a high or low wage earner. This distinction is made to evaluate whether MAPP is any more or less cost effective for participants who engage in substantial work.

Health Care Expenditures

Medicaid claims data were classified by category of service to describe the amount Medicaid paid for services used by MAPP participants. Medicaid expenditures for MAPP participants are compared to Medicaid expenditures for people who do not participate in MAPP, but are otherwise similar in terms of age, sex, medical status, county, Medicare or third party insurance coverage, prior experience in Medicaid, and expenditure-related illness burden. The study population excludes individuals who resided in a long-term care institution at any time between 1999 and 2003, and excludes expenditures for long-term care. Severely disabled individuals generally do not participate in MAPP. Institutional expenditures account for less than 1% of total MAPP spending for health services.

Total outlays for health care utilized by MAPP participants while enrolled in MAPP were $3.6 Million in the first full program year (PY1: beginning 4/1/2000 and ending 3/31/2001), $13.5

[35] MAPP participants are required to report their earnings at enrollment, after a change in income and at 12 month intervals following enrollment, using the CARES system. Earned income data for this analysis was taken from the last month for which a respondent was identified in the CARES data, through June 2003.

Million in the second full program year (PY2: beginning 4/1/2001 and ending 3/31/2002) and $25.5 Million in the third program year (between 4/1/2002 and 3/31/2003). The increase in total spending over time is due largely to the rise in the number of program participants over time. The table below shows the amount spent in each year by category of service.

Amount Paid for MAPP Program Participants While They Were Enrolled in MAPP
Non-Institutional Population & Non-Institutional Claims by Program Year and Category of Service[36]

Category of Service	Program Year One Amount Paid (N=1,212)	Year One Percent	Program Year Two Amount Paid (N=2,514)	Year Two Percent	Program Year Three Amount Paid (N=4,178)	Year Three Percent
Prescribed Drugs	$1,455,582	40.27%	$6,635,355	49.20%	$11,741,114	46.03%
Capitation Payments	$574,314	15.89%	$1,541,070	11.43%	$3,216,938	12.61%
Inpatient Hospital Services	$358,568	9.92%	$710,768	5.27%	$2,379,815	9.33%
Other Care	$441,353	12.21%	$1,292,087	9.58%	$2,335,466	9.16%
Home Health Services	$246,410	6.82%	$977,921	7.25%	$1,434,052	5.62%
Professional Cross-overs	$177,740	4.92%	$610,374	4.53%	$1,342,527	5.26%
Outpatient Hospital Services	$73,805	2.04%	$220,760	1.64%	$711,641	2.79%
Clinic Services	$102,483	2.84%	$394,319	2.92%	$699,311	2.74%
Institutional Cross-overs	$61,893	1.71%	$200,608	1.49%	$467,940	1.83%
Other Practitioners Services	$11,182	0.31%	$515,596	3.82%	$426,200	1.67%
Physicians Services	$33,776	0.93%	$100,425	0.74%	$236,288	0.93%
Dental Services	$31,735	0.88%	$141,790	1.05%	$212,682	0.83%
Lab and X-Ray Services	$27,838	0.77%	$95,069	0.70%	$210,899	0.83%
Family Planning Services	$6,734	0.19%	$35,583	0.26%	$50,983	0.20%
CCO	$10,184	0.28%	$13,646	0.10%	$30,141	0.12%
Rural Health Clinic Services	$978	0.03%	$1,951	0.01%	$8,925	0.03%
EPSDT	$97	0.00%	$246	0.00%	$311	0.00%
Total Amount Paid	$3,614,673	100.00%	$13,487,568	100.00%	$25,505,232	100.00%

Comparison group expenditures in 2003 were slightly different than the MAPP expenditures when examined by category of service. Excluding institutional expenditures, prescribed drugs account for the highest percentage of expenditures, followed by capitation payments and inpatient hospital services, for both groups. However, it is interesting to note that as a percentage of total expenditures, pharmacy costs are almost 50% higher for MAPP participants than the comparison group. This may be due, in part, to the fact that a larger percentage of comparison group members appear to be participating in managed care programs where prescription drugs are included in the capitated benefit.

[36] Figures from program years one and two as presented in the 2002 Annual Report differ from the year one and two figures presented in this report due to claims adjustments during the previous 12 months and query adjustments, which capture all detail level paid amounts on each individual claim, and the institutionalized population and long-term care expenses are excluded. As a result, the expenditures per FYE are also affected. The most current data is presented in this report.

Amount Paid for MAPP Program Participants and Comparison Group Non-Institutional Expenditures for Program Year Three by Category of Service				
Category of Service	**Program Year Three Amount Paid (N=4,178)**	**Year Three Percent**	**Comparison Group Program Year Three Amount Paid (N=11,295)**	**Comparison Group Year Three Percent**
Prescribed Drugs	$11,741,114	46.03%	$27,856,515	30.81%
Capitation Payments	$3,216,938	12.61%	$19,558,555	21.63%
Inpatient Hospital Services	$2,379,815	9.33%	$14,587,851	16.13%
Other Care	$2,335,466	9.16%	$3,998,454	4.42%
Home Health Services	$1,434,052	5.62%	$10,402,381	11.50%
Professional Cross-overs	$1,342,527	5.26%	$3,693,822	4.09%
Outpatient Hospital Services	$711,641	2.79%	$2,168,568	2.40%
Clinic Services	$699,311	2.74%	$2,547,169	2.82%
Institutional Cross-overs	$467,940	1.83%	$1,317,930	1.46%
Other Practitioners Services	$426,200	1.67%	$1,944,015	2.15%
Physicians Services	$236,288	0.93%	$773,216	0.86%
Dental Services	$212,682	0.83%	$501,279	0.55%
Lab and X-Ray Services	$210,899	0.83%	$757,752	0.84%
Family Planning Services	$50,983	0.20%	$145,292	0.16%
CCO	$30,141	0.12%	$140,378	0.16%
Rural Health Clinic Services	$8,925	0.03%	$27,123	0.03%
EPSDT	$311	0.00%	$1,056	0.00%
Total Amount Paid	$25,505,232	100.00%	$90,421,355	100.00%

Putting each year's expenditures on a common basis gives a better picture of average resource utilization by those enrolled in MAPP. Summing the total months of MAPP enrollment and dividing by 12 yields a "full-year equivalent" (FYE) on which to base average spending for annual comparisons. The following table gives a summary of program enrollment and spending per FYE.

MAPP Program Enrollment and Payment Summary by Program Year				
	MAPP Year One	**MAPP Year Two**	**MAPP Year Three**	**Comparison Group Year Three**
Total Amount Paid	$3,614,673	$13,487,568	$25,505,232	$90,421,355
Count of Individuals Using Services	1,101	2,360	4,037	9,939
Count of Individuals Enrolled	1,212	2,514	4,178	11,295
Percent of Individuals Using Services	90.8%	93.9%	96.6%	88.0%
Full-Year Equivalents (FYE)	544	1,482	3,096	9,936
Amount Paid per FYE	$6,645	$9,101	$8,238	$9,101

A distinction may be made between MAPP participants who are high or low wage earners. The following table shows the enrollment and payment summary for these two groups separately.

MAPP Enrollment and Payment Summary by Program Year and Participants' Earned Income Level			
A. High Wage Earners	**Program Year One**	**Program Year Two**	**Program Year Three**
Total Amount Paid	$244,405	$950,304	$1,776,621
Count of MAPP Participants Using Services	66	147	275
Count of Distinct Individuals Enrolled in MAPP	71	160	291
Percent of Participants Using Services	93.0%	91.4%	93.0%
Full-Year Equivalents (FYE)	31	93	197
Amount Paid per FYE	$4,214	$6,912	$6,706
B. Low Wage Earners	**Program Year One**	**Program Year Two**	**Program Year Three**
Total Amount Paid	$3,370,268	$12,537,265	$23,728,611
Count of MAPP Participants Using Services	1,035	2,213	3,762
Count of Distinct Individuals Enrolled in MAPP	1,141	2,354	3,887
Percent of Participants Using Services	90.7%	94.0%	96.8%
Full-Year Equivalents (FYE)	513	1,388	2,899
Amount Paid per FYE	$6,570	$9,033	$8,185

These tables show many changes over the first three years of MAPP implementation. As enrollment has ramped up over time, the average length of an enrollment period and the proportion of participants who use health services have increased. Taking into account the total number of months persons were enrolled in each period, spending has kept pace with enrollment and other changes. The inter-annual fluctuation in relative spending per eligible year obscures a slight upward trend over time. The comparison group has higher spending per FYE in most time periods, but a fair comparison between groups can be made only when potential confounding factors have been accounted for. We turn now to the methods used to make group comparisons of adjusted means, holding individual's background characteristics equal between groups.

Comparison Group

While there may be an increase in average spending for MAPP program participants, there also appears to be an upward trend in spending for Medicaid overall. We can check this by using a comparison group of Medicaid recipients who are similar to MAPP participants. We selected a comparison group in several steps. First, we examined the MAPP participants who had prior experience in Medicaid, and we selected all Medicaid recipients who had the same "medical status code", which is the eligibility criterion that qualifies an individual for enrollment. Next, we determined which combinations of codes, county, and age-group most strongly distinguished those Medicaid recipients who entered MAPP, and those who did not, using logistic regression.[37] The predicted probability of entering MAPP was calculated and those with the highest

[37] Logistic regression is used where the dependent variable is categorical to estimate the conditional odds of being in one category versus another.

probability were selected as the comparison group most similar to MAPP participants. The comparison group includes 11,295 individuals.

Multiple Regression

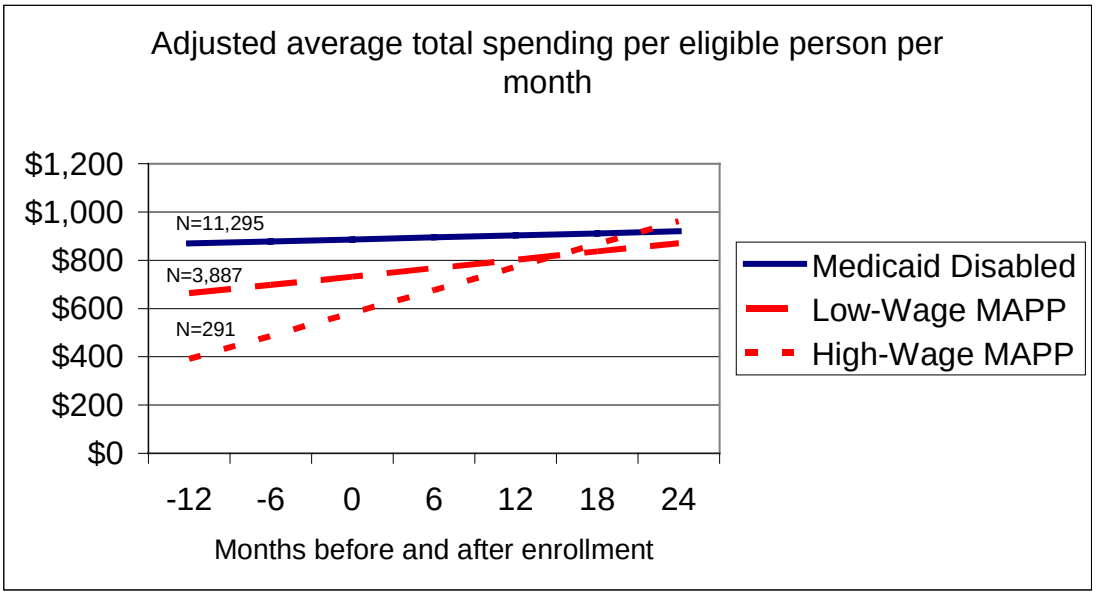
As the tables above show, with so many things changing it is difficult to separate the effect of MAPP on average spending from the effects of other variables. Therefore, we must use multivariate statistical methods to control other sources of variation in spending and isolate the effect of MAPP program participation. The comparison of average spending between these groups was further refined by using multiple regression analysis to control for differences in health status, prior Medicaid experience, and eligibility for Medicare or private third party health insurance coverage. The following analysis was conducted using all eligible months during the time period April 1, 1999 through March 31, 2003, excluding individuals who resided in an institution at any time during that period.

An index of illness burden was computed using the Chronic Disease and Disability Payment System (CDPS)[38] to group diagnoses from claims for services rendered in each of the eight six-month periods beginning in April, 1999, and ending in March, 2003. Higher CDPS index numbers indicate greater illness burden than lower index numbers. Amounts Medicaid paid per person per month for those claims were summed by category of service for each individual, and divided by the number of months each individual was eligible. Finally, the number of months elapsed between the claim service date and the individual's first MAPP enrollment date (or a randomly assigned pseudo-enrollment date for the comparison group) was measured to test for trends over time and differences before and after MAPP enrollment.

The analysis shows that total health care spending per person per month at the time of enrollment for the MAPP participants is significantly lower**,** on average, than for the comparison group of disabled Medicaid recipients. Although this initial difference is significant, the difference between groups diminishes over time. Excluding institutional services that MAPP participants generally do not use, **total health care spending** is lower on average, for both the high wage and low wage earning MAPP participants, as compared to the disabled Medicaid comparison group. However, the group averages converge and are not significantly different after approximately two years in the program. Results of the regression analysis for total spending per person per month can be found in *Attachment I.*

There was no significant **trend** in spending over time for either the MAPP high-wage earners or the comparison group, but spending per person per month appears to be trending upward for the MAPP low-wage earners. The graph on the following page depicts the regression estimates for the level and trend in spending over time for these three groups, holding all other variables equal. This shows how group means have changed over time, adjusted for individual differences in prior Medicaid experience, illness burden, and coverage by Medicare or third party insurance.

[38] The CDPS software was developed by R. Kronic and others at the University of California at San Diego.



There was no statistically significant rise in the Medicaid disabled comparison group spending over the four-year observation period, nor did MAPP participants' total non-institutional spending increase at a significant rate. The trends for MAPP participants are estimated to be larger, but the small number of participants and wide variability in the groups prevent strong conclusions that the effects are not simply due to chance. In other words, we cannot rule out that the slope of the line for MAPP participants might actually be flat, or parallel to the comparison group line.

At the time of enrollment, both the low-wage and the high-wage group of MAPP participants have significantly lower average spending than the comparison group, but average non-institutional health care spending for the MAPP high and low wage earners is not significantly different from the comparison group after 24 months of enrollment. The analysis describes trends observed during the study period, but the linear trend should not be used to extrapolate future expenditures.[39]

When total (non-institutional) spending is broken out by major categories of service, we see more clearly what kind of spending accounts for differences between MAPP participants and other disabled Medicaid recipients. Detailed findings for each category of service can found in *Attachment I.*

The high-wage MAPP participants have slightly lower hospital outpatient spending, and the larger group of low-wage MAPP participants has significantly lower home health care spending, and significantly higher spending on drugs than the comparison group, on average. Otherwise, there is little distinction between MAPP participants' patterns of health care expenditures and those of comparable disabled Medicaid recipients. Individuals' illness burden, and whether or not one is eligible for Medicare, has third-party insurance coverage, or has prior experience with

[39] Though not shown in the graph, after approximately 36 months in MAPP, the rate of expenditures begins to decline. It appears that over time, MAPP expenditures have "regressed to the mean," and become very similar to the comparison group expenditures depicted in the graph above.

Medicaid seems to have a much greater influence on Medicaid spending per person per month than does MAPP program participation[40], as one would expect since Medicare is a primary payer to Medicaid.

Conclusions

This fiscal evaluation has monitored the effects of MAPP on State and Federal Medicaid expenditures and examined the spending patterns of low-wage and high-wage MAPP earners. The principal findings are:

- MAPP participants tend to spend less than the comparison group from the time of enrollment through approximately 24 months after enrollment in the program. However, the rate of increase in expenditure is slightly higher during this period for MAPP participants, so that over time, the MAPP and comparison group rates of expenditure have converged to become very similar.

- Compared to similar Medicaid recipients, the low-wage MAPP participants earning below SGA have slightly higher spending on drugs, but significantly lower home health care spending. The high-wage MAPP participants have significantly lower spending on hospital outpatient services than the comparison group.

- With the exception of the differences noted above, there is little distinction between MAPP participants' pattern of health care expenditures and those of comparable disabled Medicaid recipients not enrolled in MAPP.

- The relatively small MAPP population size and high individual variability may partially explain the general lack of significant differences between MAPP participants and comparable Medicaid participants. However, the sample is of sufficient statistical power to determine that MAPP program participation has significantly less fiscal impact than participation in Medicare, prior participation in Medicaid, or private third-party insurance coverage.

[40] This phenomenon was analyzed and discussed in detail in the MAPP 2002 Annual Report.

VI. Process Evaluation

The purpose of the Process Evaluation is to determine whether MAPP was implemented equitably across the State and to evaluate whether the program, as currently designed, is efficient and effective. As previously discussed, the recipient surveys included questions intended to provide information on the enrollment process and the administration of the program from the recipient's point of view.

In year one, the Process Evaluation was based on information collected through a number of informal venues, such as key informant interviews, and through analysis of administrative data. That evaluation resulted in the identification of a number of process issues related to the state and county administration of MAPP. The year two report summarized the year one findings and subsequent actions taken by the State to address those issues, in addition to providing a summary of selected findings[41] from the recipient and ES worker surveys. The year three report reviews the findings from year two; updating progress on the process issues addressed in the second annual report, and adds new data from the Initial, Six Month Follow-Up and Disenrollment Surveys related to the implementation of MAPP from the participant's perspective.

Income Distribution

The distribution of earned income among MAPP participants was examined. There are disproportionately more $0 wage earners in Milwaukee, Kenosha, Washburn and LaCrosse Counties.[42] For instance, Milwaukee County accounts for just under 10% of the MAPP population over time, but accounts for almost 21% of the $0 wage earners. Interestingly, Washburn County accounts for only 2% of all MAPP participants, but 8% of the $0 wage earners. In addition, Milwaukee and Dane Counties represent a disproportionate number of high wage earners, as well.[43] Dane County accounts for 16.7% of the high wage earners, but only 10% of the overall population, and Milwaukee County accounts for 16% of the high earners, but less than 10% of the entire population.

These findings suggest one of two things is occurring in these counties. Either the county populations tend to cluster on the very low and very high ends of the earnings spectrum, or there is a process issue at work during the enrollment and recertification process in these counties that artificially increases the number of very low or very high earners. In the case of Milwaukee and Dane Counties, it seems more likely that they would have larger populations at the very low and very high ends of the wage distribution, but in Washburn County, one would not expect their participants to cluster at the $0 earner level, unless there is a process affect occurring during enrollment. High income jobs are more prevalent in Milwaukee and Dane Counties, and it is likely that they also have a larger percentage of low income individuals, both of which suggest that other factors besides process issues are at work in these counties. However, in the case of LaCrosse, Kenosha, and particularly Washburn County, a process affect is more likely. These findings may warrant further investigation by CDSD at the county level.

[41] A separate comprehensive report on the ES Worker Survey was provided to CDSD in September 2002.
[42] Not all counties were checked for this analysis; however, the counties identified above provided the most disparate percentage of $0 wage earners relative the distribution of the entire MAPP population.
[43] High wage earners are those earning more than $1,249 per month.

Premium Structure

The first year Annual Report identified concerns about the equitability of the structure of the premium calculation formula. The MAPP definition of income for premiums treats earned and unearned income differently. One's premium liability does not increase proportionately to one's increase in total income. Rather, it increases disproportionately with one's increase in unearned income as a result of the formula. MAPP participants are required to contribute 3% of their adjusted earned income toward their premium, while they are required to contribute 100% of their adjusted unearned income if their total income is above 150% of the Federal Poverty Level (FPL). The effect of this disparity is that individuals with the same total income, but with different ratios of earned and unearned income could be paying significantly different premiums. While this effect was intended by program developers to provide a strong work incentive, it has since been identified as inequitable by a variety of program stakeholders.

In the first year of the evaluation, premium payment and earnings data were analyzed to assess the efficacy of the premium structure in terms of providing work incentives. This analysis was repeated for this report with the addition of a fifth classification of premium payers. The following table provides the median earned and unearned income for five groups of participants: (1) individuals with no premium liability; (2) $25 premium payers; (3) $50-$100 premium payers; (4) $125-$500 premium payers and (5) individuals paying premiums in excess of $500.

Earned and Unearned Income by Premium Liability

	Number of Participants	Median Earned Monthly Income	Median Unearned Monthly Income
No Premium Liability[44]	4,146	$87	$735
$25 Premium	107	$1,046	$618
$50-$100 Premium	145	$562	$725
$125-$500 Premium	222	$504	$895
Over $500 Premium	22	$107	$1,263
Total	**4,642**	**$120**	**$740**

This year's analysis suggests that the premium structure is effective in providing work incentives. Individuals with high levels of earned income are paying lower premiums than their lower earning counterparts. Questions were raised in last year's report regarding the relationship between earned and unearned income and its impact on the premium calculation. The premium structure was predicated on the assumption that as MAPP participants increased their earnings there would be corresponding reductions of unearned income. Last year's analysis suggested that there may not be such a direct relationship for some of the MAPP participants.

With the current premium structure, it is possible to have participants with very similar total incomes paying very different premiums. For example, there was only a difference of $52 in total income between the median $50-$100 premium payer and the over $100 payer. However,

[44] All data for this table were taken from the June 2003 CARES data extract.

the gap between the $125-$500 median payer and the over $500 payer in this year's analysis is $397. Further analysis in 2003 shows that earned and unearned income are inversely correlated. As earned income increases, unearned income decreases.[45] This finding is reinforced by comparing the unearned income between the highest earned income premium group ($25 payers) and the lowest earned income premium group (>$500). The highest earned income group has significantly lower unearned income than the lowest earned income group, $618/month, as compared to $1,263/month, respectively. Although these findings support the assumption that unearned income decreases with increases in earned income, they do not address the actual premium calculation, which still allows for the possibility of low earners with relatively low unearned income paying relatively high premiums.

The majority of survey respondents who were paying a premium indicated that their premium was at least "somewhat" affordable. Seventy-three percent of the initial and 67% of the follow-up respondents felt that their premium was at least somewhat affordable.

To emphasize the continued debate over the current premium structure and reiterate findings from 2002, the ES worker survey included a number of open-ended questions that generated feedback about the premium structure. Data collected on the program's premium structure suggests that workers have identified individuals who "need MAPP," but are unable to participate in the program because the premiums would be too costly. The majority of respondents who commented on the premium structure indicated that the premiums were too high. In addition, approximately 22% of all comments related to the efficacy of MAPP related to concerns about the high cost of the MAPP premiums. Workers were also concerned about the "cliff effect" of the premium structure. For example, with a change of $.01 in income, an individual can go from having no premium liability to having a premium of a few hundred dollars, depending upon the individual's monthly unearned income. CDSD has explored several alternatives to the current premium structure, but no other method of premium calculation appears to be more equitable for all MAPP participants.

Independence Accounts (IAs)

Very few IAs were registered during the first year of the evaluation. Only 1% of participants had registered accounts, which suggests one of three things: (1) participants are not taking advantage of this program benefit; (2) participants are not aware of this program benefit; and/or (3) ES workers were not documenting these accounts.

IAs continued to be an underutilized benefit in 2002 and that pattern has continued in 2003. As of June 2003, CARES reports 72 active IAs representing 58 program participants, still only 1% of the current participants. A zero balance was reported for 38% of all accounts. Considering that 38% of the accounts report a zero balance there does not appear to be any increase in savings toward independence. There are, however, a handful of individuals who have used this benefit to set aside significant assets. Nine accounts have a registered balance greater than or equal to $10,000. Five of these accounts are IRAs, two are savings accounts, one a credit union account and the last is a checking account.

[45] These findings are significant at the .01 level.

ES workers are supposed to enter IA data if it is available; however, CARES does not make it mandatory in order to complete the eligibility determination. Therefore, it is still unclear as to which one or more of the three aforementioned reasons is the cause of the low number of accounts. This issue would need to be resolved with the counties and with the data managers for CARES, before an evaluation of this program component could be conducted.

Milwaukee County Enrollment

As discussed in the initial Annual Report, given Milwaukee County's proportion of the disability-related Medicaid caseload, the county's MAPP enrollment was lower than expected. At the time of the first Annual Report, Dane County had certified 2.5 times the number of MAPP participants as Milwaukee County, but Milwaukee County had more than five times the number of disability-related Medicaid eligibles. Anecdotal information gathered from PTI Benefits Specialists in June 2001 also reinforced the assumption that there were some challenges with program implementation in Milwaukee County. Findings in the 2002 report also supported the under representation of Milwaukee County participants in MAPP. Figures from 2003 show mild improvement, but Milwaukee County remains behind Dane county in enrolling MAPP participants. However, the gap between the counties is closing. Currently, Dane County accounts for 10% of the MAPP population and Milwaukee accounts for 9%, but Milwaukee county still accounts for almost 30% of the statewide disabled population, compared to under 6% for Dane County.

Waiver Status

Community Integration Program (CIP) IA, CIP IB and CIP II are home and community based waiver (HCBW) programs that provide a federal MA waiver and federal funding to move many of the state's developmentally disabled, physically disabled and elderly residents from institutions to the community. Community Options Program (COP)-R is a similar program that provides additional **state** resources to move these individuals out of institutions and into the community. COP-R **is not** an MA waiver program. COP-W (COP-Waiver), however, **is** an MA waiver program that supports the community integration of the physically disabled and elderly with federal funding.

A small percentage of MAPP participants are participating in a HCBW while on MAPP. COP-R is supported entirely with state funds and there are a number of restrictions on how these funds can be used for individuals who are also eligible for community based waiver programs, such as COP-W and CIP. The ability to convert individuals from COP-R to COP-W is a matter of fiscal importance to the state because COP-W services are eligible for federal Medicaid match, while COP-R services are not. It was expected that through MAPP eligibility requirements some COP-R participants would be eligible for and converted to the COP-W program, but findings from the first year of the evaluation suggested that these conversions may not have occurred.

The number of MAPP COP-R participants in August 2002 (149) versus COP-W participants (47) continued to raise questions about why there continued to be more MAPP participants participating in COP-R than COP-W. Current figures show the same pattern of enrollment in COP-R and COP-W. As of August 2003, 239 MAPP participants were enrolled in COP-R, while only 102 were enrolled in COP-W. Also, the percent of MAPP participants on waivers has steadily increased from 13% in 2001, to 16% in 2002, and now to 19%, as of August 2003.

There are a number of reasons that counties may not be able to or may not want to complete these conversions. For example, COP-R participants who are chronically mentally ill or who have Alzheimer's disease are not eligible for Medicaid waiver services, including COP-W. There are also specific services available under COP-R that are not available under COP-W.

Throughout 2002, CDSD was working to obtain diagnosis data from the DHFS Disability Determination Bureau (DDB). Unfortunately, the data was not available in time for the 2002 Annual Report. The evaluators, through CDSD, did obtained limited diagnoses data from the DDB late in 2002; however, the data contained only a small subset of MAPP participants. DDB provided the evaluators with a list of 1,988 unique social security numbers (SSN), or 41% of the August 2003 MAPP population. Using these SSNs, it was possible to match 218 waiver participants with diagnosis data. As was expected, 72% of the matched participants had a designation denoting a mental health condition. Also, of the 1,988 MAPP participants with DDB data available, 59% had a designation denoting a mental health condition, and over 30% had a diagnosis code related to a mental health condition. Both findings suggest that the limited number of MAPP participants enrolled in COP-W is largely due to the eligibility criteria of the waiver and the disability make-up of the MAPP population. *Attachments J*, *K* and *L* in section VIII Appendix provides additional detail on the waiver status of MAPP participants and their DDB diagnosis grouping.

HEC Program Improvements

In the first year of the evaluation, it was discovered that a significant number of MAPP participants reported $0 in earned income, but were not enrolled in the HEC program. In order to be eligible for MAPP, an individual is supposed to be working or enrolled in the HEC program. The high number of individuals who appeared to be doing neither raised concerns about the effectiveness of the HEC program. As of July 2002, there were still a significant number of individuals (206) who reported $0 income, but were not participating in HEC. As of June 2003, there were 534 MAPP participants who reported $0 earnings, and only 94 current HEC participants.

As reported in last year's report, CDSD was able to identify a number of HEC program issues that contributed to the low number of enrollments, including:

- HEC screeners have full-time duties with their employers and do not have a strong identification with the program.
- Insubstantial and ineffective marketing support for MAPP or HEC
- Limited outreach to the disability community

In addition to the reasons cited above, the majority of the screeners had only a cursory understanding of benefits analysis and benefits planning as they related to individuals with disabilities. Also, as unpaid assistants, the screeners had not been asked to serve consumers that were not clients of their agencies or to engage in HEC program outreach.

CDSD took a number of steps to improve the effectiveness of HEC. For example, seven new .2 FTE Regional HEC Screeners were hired and a Statewide HEC Coordinator employed by Employment Resources, Inc. (ERI) was assigned in late 2001/early 2002. A considerable

amount of effort was also directed toward improving outreach for HEC in 2002. ERI staff presented information on HEC and MAPP to new PTI Benefits Counselors and Family Care Disability Benefits Specialists during a nine day benefits counseling training in February. Outreach was also conducted through the Bureau of Community Mental Health's monthly teleconference to the Wisconsin Public Psychiatry Network on January 24, 2002. However, some HEC screeners reported that they were still having difficulty finding the necessary time to promote HEC because they are kept busy answering questions about MAPP.

Given the importance of HEC in supporting a successful buy-in program, CDSD and the evaluators have planned an additional evaluation of HEC in early 2004 to measure the effectiveness of the process improvements made in 2002. The evaluators will work closely with CDSD to formulate a series of specific questions stemming from the 2002 annual report, which will then drive the structure of the upcoming HEC analysis. Specific attention will be paid to the MAPP participants who report $0 earned income, but have yet to participate in HEC.

Program Outreach

A new issue related to the effectiveness of the MAPP program was brought to light by the ES worker survey in 2002 – the ability of the program to reach "those who need it". Fewer than 15% of respondents to the ES Worker Survey rated MAPP as better than other programs on any of the program elements listed on the survey. Specific areas where MAPP rated poorly also included ES worker training and the quality of program outreach.

Almost 49% of the respondents rated MAPP as worse than other programs in terms of its ability to identify and inform people who may be eligible for the program. The HEC Regional Screeners also reported hearing from ES workers that lack of available information on HEC is a major obstacle to fully understanding and implementing MAPP accurately and efficiently. ES workers were able to provide a number of specific strategies for conducting successful outreach, such as targeting outreach to professionals who routinely interface with the target population.

CDSD has been working on expanding MAPP outreach and is developing possible strategies such as updating and expanding the MAPP website and creating Club MAPP. Club MAPP would be an extensive "in-reach" program designed to provide the current MAPP population with succinct information regarding the work incentives available through enrollment in MAPP. Club MAPP will send this information directly to the buy-in participants and also offer a bulletin-board system to share accurate information on the return to work efforts of participants. The bulletin-board format will help establish peer support groups, which can meet in the One-Stop Job Centers to share "best-practices" regarding returning to work or just beginning to pursue work as a goal. In addition, expansion of the current MAPP page on the DHFS website is being considered.

Recipient Perspective

The recipient survey also provided additional information on the effectiveness of MAPP administration. Over 79% of the respondents to the Initial Survey agreed or strongly agreed that enrolling in MAPP was easy. However, over 53% of initial respondents strongly disagreed, disagreed or were unsure of whether or not they understood all of the MAPP rules and regulations, as compared to 48% of follow-up respondents. This slight change is to be expected

as people become more familiar with MAPP over the course of their participation; however, the 5% decrease is not significant. Most respondents to both surveys felt that MAPP was explained clearly, but there was considerable ambivalence regarding MAPP written materials. Over 36% of initial respondents and 38% of follow-up respondents neither agreed nor disagreed that they were easy to understand. This finding supports feedback from TMG which stated, "Many people do not have any written information about MAPP – cannot answer questions about whether those materials are any good. Most claim to have never received any written materials specific to MAPP, prior to getting the survey mailing." This suggests that any past outreach efforts are not finding their way to the end consumer of the service.

The majority of initial (76%) and follow-up (73%) respondents are comfortable asking questions about MAPP. Most respondents also indicated that they know who to ask if they have questions about the program, presumably their eligibility worker. When rating eligibility workers on several indicators, significant differences became apparent between the initial and follow-up respondents. On each of the following four questions, the initial respondents rated their eligibility workers significantly higher than the follow-up respondents.

1. The eligibility worker/MAPP staff spent/spends enough time with me.
2. I was treated with respect and dignity by the eligibility worker/MAPP staff.
3. My culture was respected by the eligibility worker/MAPP staff.
4. My eligibility worker/MAPP staff was helpful.

This finding is difficult to interpret; however, limited contact after the initial application period may lead to lower ratings of the workers over time.

In addition, items 1. and 2. above, as well as the statement: "I have been included in all of my MAPP decisions" showed significant differences among follow-up respondents when broken out by monthly earned income. Higher income earners tended to rate these items lower than lower income earners. Higher income earners may require more contact with their eligibility workers in order to maintain full eligibility in the program, or they may be more aware of the program's benefits and therefore have greater expectations of their eligibility worker.

Also of note, almost half of the initial (44%) and follow-up (57%) respondents indicate that they do not fully understand their financial options. As evidenced by the larger percentage of follow-up respondents who do not fully understand their financial options, this feeling does not diminish with extended participation in MAPP.[46] It may be that once a recipient begins accessing services through MAPP, the policies and procedures appear even more complex than at enrollment, causing confusion or difficulty with the program and/or the eligibility workers.

Respondents to each survey were given an opportunity to provide additional feedback on their experiences with MAPP by responding to several open-ended questions. A total of 936 comments were collected. Respondents who have been well-informed about MAPP, or who have investigated the program on their own and generally understand the eligibility requirements

[46] Although the difference in understanding financial options is not significant between the initial and follow-up respondents, it would be expected that the participants' understanding would increase with experience in the program, not decrease.

and program benefits are very pleased with the program. The most common comment in this regard is that without MAPP many of the participants could not afford their medications. Several respondents commented that MAPP is helping them work, save and generally participate actively in the community. These comments are particularly prevalent among the follow-up responses, suggesting that MAPP does have a positive impact on a subset of program participants, particularly after extended enrollment in the program.

However, there still appears to be significant confusion regarding MAPP eligibility, enrollment, benefits and general program information. As stated by the TMG interviewers and reinforced by the survey findings, a significant number of the survey comments also suggest that the participants are still not clear on what MAPP is or why they are enrolled in the program. For example, one comment stated, "I do not really understand the program. My social worker just told me I would qualify for this new program which would mean she would not have to review me again until next June." Or, "…MAPP worker has not explained how anything works or what can be expected. Guardian was just handed pamphlets and participant was not even spoken to…" In addition, while the majority of MAPP participants are satisfied with the time spent with them by their county worker, open ended comments suggest that not all workers are effectively conveying program policies and options to potential participants and current participants. The following excerpt from a TMG interviewer summarizes these sentiments, "I think the county is the agency that lacks communication. The county workers do not offer MAPP to people. People have told me they have had to tell their county worker about the MAPP program." The interviewer goes on to suggest that many survey respondents are "very" concerned about losing their Medicaid benefits, and the lack of communication/knowledge of MAPP by the county contributes to this fear.

Numerous respondents feel strongly that MAPP eligibility criteria and enrollment procedures are simply too complex and confusing. Several respondents with college or post-graduate experience noted that they have difficulty understanding the program, and that the eligibility criteria and available benefits are too confusing for many people with disabilities. It's difficult to determine if the confusion over MAPP eligibility and benefits is due mostly to a lack of communication between the state and county, and the county and participant; or if the eligibility criteria and benefits are truly too complex to navigate for most people. The data suggests that the lack of outreach and communication between the county and participant are the major contributing factor to any dissatisfaction with MAPP.

Several suggestions were made in last year's report to increase training and provide the counties with updated information regarding MAPP eligibility, the premium determination formula and benefits available to MAPP participants, specifically the use of IAs. Although the data provided in this report re-emphasize those recommendations, the most apparent obstacle facing MAPP participants is a basic lack of understanding regarding MAPP. To fully maximize the benefits available through MAPP, participants need to be better informed about how they may qualify for the program, what benefits enrollment provides; and they must be reassured that they can earn more income and save through IAs without losing their health care coverage. Participants who begin to take full advantage of the benefits available to them through MAPP by earning more income and saving for their personal needs, may also positively impact the cost effectiveness of the program.

Further Analyses

Through discussions with CDSD, the evaluators have prioritized a list of future MAPP evaluation activities to be completed during the 4th quarter of 2003. These activities are designed to strengthen the findings presented in this report, as well as fill gaps where impact, cost-effectiveness or process questions remain unanswered. Using some of the findings from this report, in conjunction with possible new data collection, the evaluators will examine the following topics:

- Complete administration of the 12-Month, 24-Month and Disenrollment Surveys and provide a final analysis of each.
- Further examine the extent to which MAPP participant earnings come from self-employment or in-kind compensation.
- Examine MAPP enrollee tenure, including a profile of the length of participation in the MAPP program.
- Use the Chronic Illness and Disability Payment System (CDPS) grouper to generate a co-morbidity score for all MAPP participants based on diagnosis and utilization.
- Consider methods for collecting data on participants who earn at substantial levels, but choose to disenroll from MAPP.
- Analyze the geographic distribution of comments from the ES Worker Survey to target areas for further program outreach/training.
- Work with other states through the National Consortium for Health Systems Development (NCHSD) to design a data collection strategy/instrument to assess barriers to work for buy-in participants.
- Identify a mechanism for collecting more information on utilization of IAs, IRWEs and MREs.

VIII. Appendix

Attachment A: Premium Schedule

PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The Premium is:	Sum of Adjusted countable Unearned and Adjusted Earned Income		The Premium is:
From	**To**	**Premium**	**From**	**To**	**Premium**
$0	$10.00	$0.00	500.01	525.00	500.00
10.01	25.00	$0.00	525.01	550.00	525.00
25.01	50.00	25.00	550.01	575.01	550.00
50.01	75.00	50.00	575.01	600.00	575.00
75.01	100.00	75.00	600.01	625.00	600.00
100.01	125.00	100.00	625.01	650.00	625.00
125.01	150.00	125.00	650.01	675.00	650.00
150.01	175.00	150.00	675.01	700.00	675.00
175.01	200.00	175.00	700.01	725.00	700.00
200.01	225.00	200.00	725.01	750.00	725.00
225.01	250.00	225.00	750.01	775.00	750.00
250.01	275.00	250.00	775.01	800.00	775.00
275.01	300.00	275.00	800.01	825.00	800.00
300.01	325.00	300.00	825.01	850.00	825.00
325.01	350.00	325.00	850.01	875.00	850.00
350.01	375.00	350.00	875.01	900.00	875.00
375.01	400.00	375.00	900.01	925.00	900.00
400.01	425.00	400.00	925.01	950.00	925.00
450.01	475.00	450.00	9950.01	975.00	950.00
475.01	500.00	475.00	975.01	1,000.00	975.00

Note: If the sum of Adjusted Countable Unearned Income and Adjusted Earned Income is greater than $1,000.00 per month, the premium shall be equal to the exact dollar amount of this sum.

Attachment B: Eligibility Trends for MAPP Participants

ELIGIBILITY TRENDS FOR MAPP ENROLLEES

Data as of July 15, 2003

MONTH OF YEAR	NEW MAPP ENROLLEES[1]	# WITH ELIGIBILITY PRIOR MONTH[2]	% WITH ELIGIBILITY PRIOR MONTH[2]	# WITH ANY PRIOR ELIGIBILITY[3]	% WITH ANY PRIOR ELIGIBILITY	# WITH POST MAPP ELIGIBILITY[4]	MAPP DISENROLLMENTS[5]	MAPP NET NEW ENROLLEES[6]
January 2000	32	7	21.9%	24	75.0%	11	0	32
February 2000	14	5	35.7%	10	71.4%	8	1	13
March 2000	40	20	50.0%	34	85.0%	21	0	40
April 2000	40	17	42.5%	34	85.0%	22	0	40
May 2000	61	32	52.5%	52	85.2%	23	3	58
June 2000	113	67	59.3%	96	85.0%	41	2	111
July 2000	133	81	60.9%	117	88.0%	49	3	130
August 2000	107	59	55.1%	93	86.9%	45	4	103
September 2000	104	52	50.0%	91	87.5%	45	7	97
October 2000	124	72	58.1%	108	87.1%	48	8	116
November 2000	117	76	65.0%	97	82.9%	38	9	108
December 2000	131	106	80.9%	120	91.6%	50	19	112
January 2001	158	87	55.1%	134	84.8%	54	13	145
February 2001	95	58	61.1%	81	85.3%	32	10	85
March 2001	99	62	62.6%	86	86.9%	33	15	84
April 2001	76	47	61.8%	67	88.2%	28	17	59
May 2001	85	56	65.9%	78	91.8%	29	24	61
June 2001	78	49	62.8%	62	79.5%	26	26	52
July 2001	80	56	70.0%	71	88.8%	21	17	63
August 2001	76	44	57.9%	66	86.8%	21	17	59
September 2001	92	58	63.0%	80	87.0%	24	25	67
October 2001	80	43	53.8%	68	85.0%	25	30	50
November 2001	93	55	59.1%	81	87.1%	30	23	70
December 2001	80	46	57.5%	65	81.3%	23	26	54
January 2002	185	115	62.2%	158	85.4%	42	34	151
February 2002	294	226	76.9%	264	89.8%	53	25	269
March 2002	241	156	64.7%	211	87.6%	63	52	189
April 2002	231	149	64.5%	194	84.0%	33	35	196
May 2002	243	155	63.8%	202	83.1%	54	51	192
June 2002	234	150	64.1%	205	87.6%	52	59	175
July 2002	264	173	65.5%	220	83.3%	46	72	192
August 2002	209	128	61.2%	175	83.7%	41	55	154
September 2002	210	134	63.8%	183	87.1%	31	54	156
October 2002	233	144	61.8%	199	85.4%	39	55	178
November 2002	192	123	64.1%	170	88.5%	22	67	125
December 2002	200	134	67.0%	174	87.0%	21	69	131
January 2003	280	187	66.8%	250	89.3%	34	107	173
February 2003	204	132	64.7%	177	86.8%	18	88	116
March 2003	222	157	70.7%	190	85.6%	11	88	134
April 2003	194	131	67.5%	173	89.2%	7	114	80
May 2003	171	119	69.6%	150	87.7%	5	85	86
Sums:	**5915**	**3768**	**63.7%**	**5110**	**86.4%**	**1319***	**1409**	**N/A**

[1] The minimum MAPP enrollment date for an individual

[2] Individuals having a non-MAPP eligibility segment with an end date between the minimum MAPP start date and 31 days prior to the minimum MAPP start date

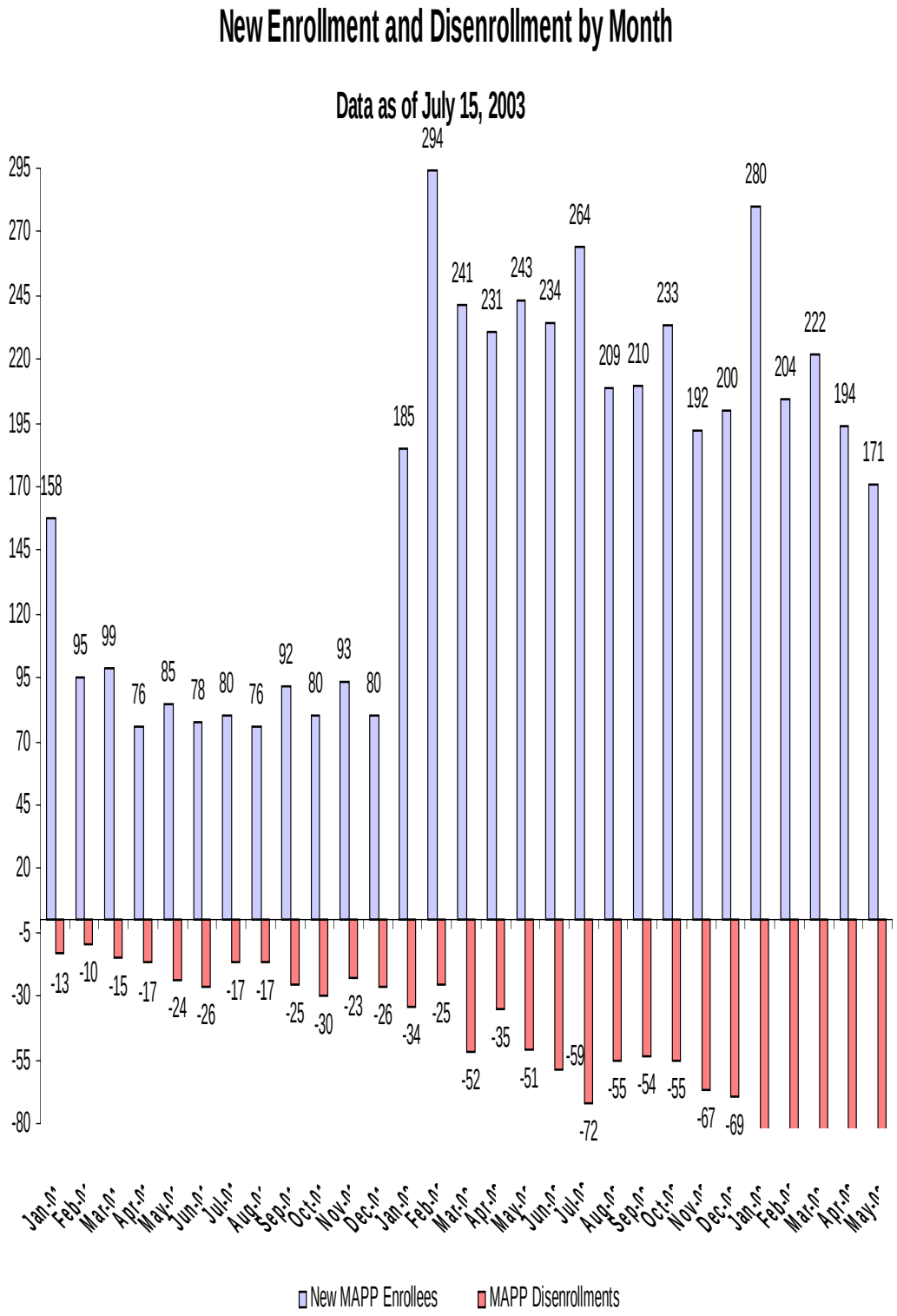
[3] Individuals having a non-MAPP eligibility segment with an end date before the minimum MAPP start date

[4] Individuals having a non-MAPP eligibility segment beginning after their minimum MAPP start date

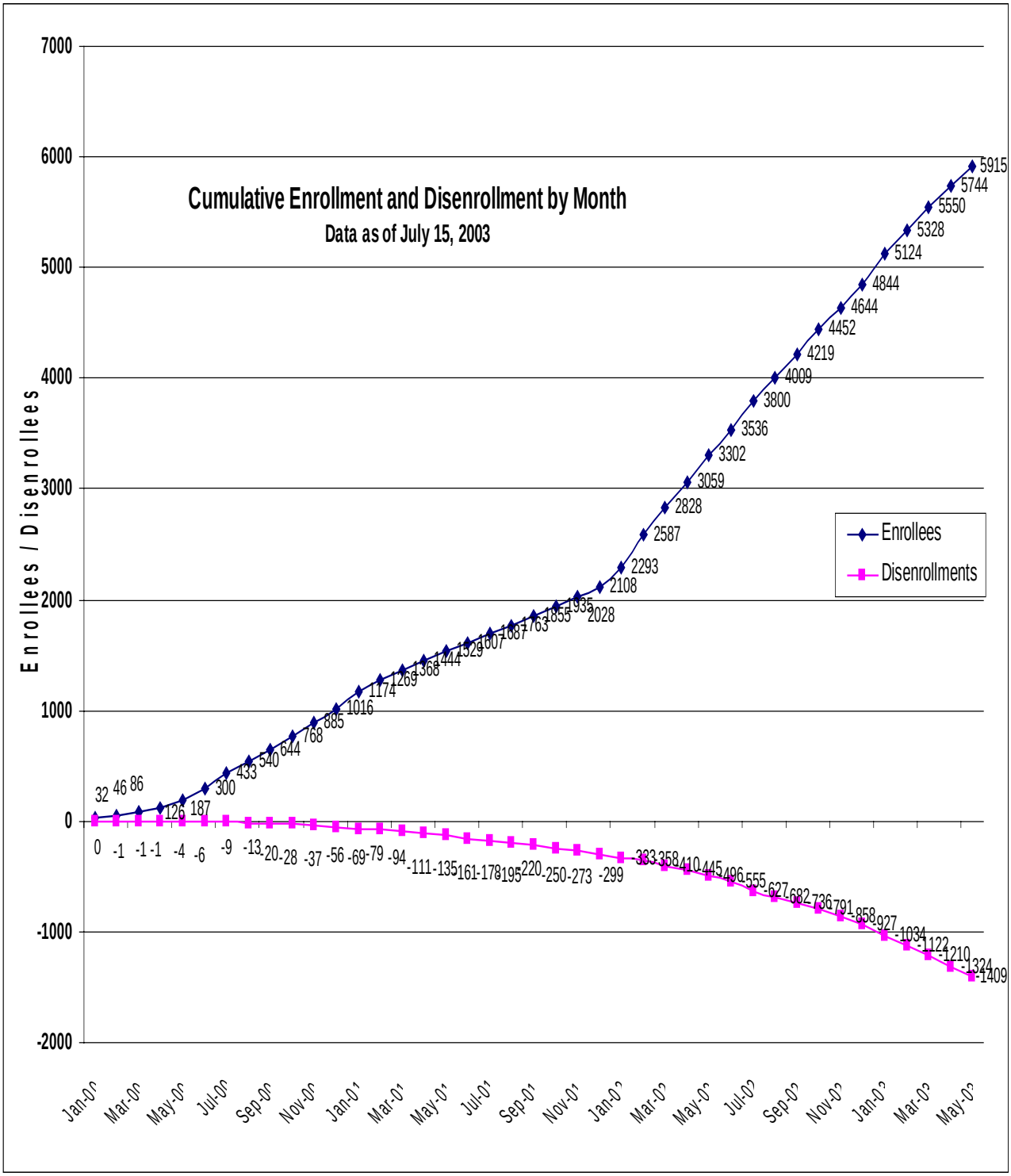
[5] The maximum MAPP end date for an individual (most recent disenrollment). Disenrollees include all MAPP enrollees that have not re-enrolled in MAPP as of the month of this report. Data is not provided for the most recent quarter because enrollees may have new eligibility segments that are not yet captured in the data. Those individuals will be included in the following quarter.

[6] New MAPP enrollees minus MAPP disenrollees for each month

Attachment C: New Enrollment and Disenrollment by Month



Attachment D: Cumulative Enrollment vs. Current enrollment by Month



Attachment E: County Breakdown of Disabled Medicaid Recipients versus MAPP Participants

County Breakout of Disabled Medicaid Recipients versus MAPP Participants (Enrollment data as of August 7, 2003)

Total Disabled Medicaid Enrollees (Including MAPP)		
County	Count	% of Total
Milwaukee	48,744	29.25%
Dane	9,681	5.81%
Racine	5,995	3.60%
Brown	5,450	3.27%
Rock	5,029	3.02%
Waukesha	4,584	2.75%
Kenosha	4,328	2.60%
Winnebago	3,763	2.26%
LaCrosse	3,746	2.25%
Marathon	3,485	2.09%
Outagamie	3,264	1.96%
Eau Claire	3,222	1.93%
Sheboygan	2,868	1.72%
Fond du Lac	2,727	1.64%
Manitowoc	2,370	1.42%
Wood	2,346	1.41%
Barron	2,162	1.30%
Waupaca	2,148	1.29%
Douglas	2,080	1.25%
Jefferson	1,885	1.13%
Walworth	1,856	1.11%
Chippewa	1,825	1.10%
Grant	1,808	1.08%
Dodge	1,678	1.01%
Portage	1,648	0.99%
Washington	1,635	0.98%
Marinette	1,618	0.97%
Sauk	1,467	0.88%
Oneida	1,322	0.79%
Columbia	1,294	0.78%
Monroe	1,277	0.77%
Shawano	1,209	0.73%
Trempeleau	1,169	0.70%
St. Croix	1,128	0.68%
Clark	1,127	0.68%
Dunn	1,081	0.65%
Polk	1,081	0.65%
Vernon	1,060	0.64%
Lincoln	995	0.60%
Oconto	957	0.57%
Juneau	924	0.55%

Current MAPP Enrollment		
County	Count	% of Total
Dane	481	10.04%
Milwaukee	418	8.72%
Kenosha	245	5.11%
Waukesha	168	3.51%
Winnebago	163	3.40%
LaCrosse	158	3.30%
Eau Claire	124	2.59%
Outagamie	123	2.57%
Marathon	115	2.40%
Racine	112	2.34%
Douglas	107	2.23%
Brown	103	2.15%
Barron	102	2.13%
Rock	101	2.11%
Washburn	98	2.05%
Sheboygan	96	2.00%
Fond du Lac	89	1.86%
Wood	89	1.86%
Green	76	1.59%
Grant	73	1.52%
Waushara	72	1.50%
St. Croix	69	1.44%
Walworth	64	1.34%
Monroe	62	1.29%
Portage	62	1.29%
Jefferson	59	1.23%
Washington	59	1.23%
Manitowoc	55	1.15%
Sauk	55	1.15%
Ashland	54	1.13%
Chippewa	51	1.06%
Calumet	47	0.98%
Vernon	46	0.96%
Trempealeau	45	0.94%
Burnett	44	0.92%
Ozaukee	44	0.92%
Columbia	43	0.90%
Clark	42	0.88%
Kewaunee	39	0.81%
Adams	38	0.79%
Marinette	38	0.79%
Price	38	0.79%

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Total Disabled Medicaid Enrollees		
County	**Count**	**% of Total**
Ozaukee	916	0.55%
Ashland	885	0.53%
Langlade	878	0.53%
Green	846	0.51%
Washburn	819	0.49%
Rusk	769	0.46%
Sawyer	740	0.44%
Waushara	734	0.44%
Crawford	730	0.44%
Price	721	0.43%
Jackson	709	0.43%
Adams	706	0.42%
Richland	692	0.42%
Pierce	649	0.39%
Taylor	649	0.39%
Door	603	0.36%
Burnett	597	0.36%
Calumet	563	0.34%
Vilas	559	0.34%
Green Lake	528	0.32%
Bayfield	514	0.31%
Kewaunee	500	0.30%
Forest	472	0.28%
Iowa	471	0.28%
Buffalo	468	0.28%
Marquette	457	0.27%
Lafayete	360	0.22%
Iron	346	0.21%
Pepin	287	0.17%
Menominee	230	0.14%
Florence	187	0.11%
Other	15	0.01%
DHSS DCS Unit (Katie Beckett)	2	0.00%
Total	**166,638**	**100.00%**

Current MAPP Enrollment		
County	**Count**	**% of Total**
Lincoln	35	0.73%
Polk	35	0.73%
Dunn	34	0.71%
Green Lake	34	0.71%
Shawano	34	0.71%
Iowa	33	0.69%
Taylor	33	0.69%
Richland	32	0.67%
Rusk	32	0.67%
Waupaca	29	0.61%
Bayfield	26	0.54%
Oneida	26	0.54%
Jackson	22	0.46%
Marquette	22	0.46%
Iron	21	0.44%
Oconto	20	0.42%
Dodge	19	0.40%
Door	18	0.38%
Langlade	18	0.38%
Sawyer	16	0.33%
Pepin	15	0.31%
Pierce	15	0.31%
Crawford	13	0.27%
Lafayette	13	0.27%
Juneau	11	0.23%
Florence	9	0.19%
Buffalo	7	0.15%
Forest	2	0.04%
Vilas	1	0.02%
Total	**4,792**	**100.00%**

Note: Disabled Medicaid recipients include individuals with the following med stat codes:

01,02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 28, 40, 41, 42, 43, 44, 45, 46, 47, 90, 91, 92, 93, A1, A2, AD, BD, 5C, 6C, 5D, 6D, DC, DD, DN, IC, IM, L1, L2, L3, L4, L5, L6, L7, L8, M3, M4, M5, M6, M7, M8, M9, MP, Q1, Q2, QN, QR, QW, RC, RN, SB W2, W3, W4, W5, W6, WA, WB, WC, WP, WR, WI, WW, ZN, ZZ

Attachment F: MAPP Enrollment by Premium Status

MAPP Enrollment by Premium Status
SFY 2001 (July 1, 2002 – June 30, 2003)

Benefit Month	Participants With Premium Med Stat Code	Participants Without Premium Med Stat Code	Total Enrollment	% of Total With Premium Med Stat Codes
July 2002	419	2,666	3,085	14%
August 2002	431	2,784	3,215	13%
September 2002	436	2,932	3,368	13%
October 2002	443	3,104	3,547	12%
November 2002	446	3,206	3,706	12%
December 2002	467	3,380	3,847	12%
January 2003	519	3,560	4,079	13%
February 2003	496	3,682	4,178	12%
March 2003	515	3,808	4,323	12%
April 2003	507	3,954	4,461	11%
May 2003	502	4,037	4,539	11%
June 2003	502	4,135	4,637	11%

Attachment G: MAPP Premium Payment History

MAPP Premium Payment History

Total Premium Payments Received July 1, 2000 - June 30, 2001
State Fiscal Year 01: $207,800

Total Premium Payments Received July 1, 2001 - June 30, 2002
State Fiscal Year 02: $491,385

Total Premium Payments Received July 1, 2002 - June 30, 2003
State Fiscal Year 03: $786,450

State Fiscal Years 01 through 03					
Benefit Month	**Payments Received**	**Average Payment**	**Maximum Payment**	**Total Paid Claims**	**Premiums as % of Claims**
July 2000	$6,785	$98.33	$475	$188,635	3.60%
August 2000	$7,975	$96.08	$625	$228,359	3.49%
September 2000	$8,345	$82.62	$625	$268,196	3.11%
October 2000	$11,385	$93.32	$675	$302,697	3.76%
November 2000	$13,600	$95.77	$675	$353,211	3.85%
December 2000	$15,655	$97.24	$675	$434,934	3.60%
January 2001	$20,085	$106.27	$675	$575,028	3.49%
February 2001	$21,900	$105.29	$675	$638,063	3.43%
March 2001	$23,640	$105.07	$750	$694,051	3.41%
April 2001	$25,000	$106.84	$750	$659,804	3.79%
May 2001	$26,605	$111.32	$750	$731,564	3.64%
June 2001	$26,825	$124.77	$750	$685,907	3.91%
July 2001	$29,635	$134.10	$750	$760,450	3.90%
August 2001	$31,760	$136.90	$750	$824,161	3.85%
September 2001	$34,425	$140.51	$875	$794,114	4.34%
October 2001	$34,465	$137.31	$875	$934,523	3.69%
November 2001	$35,465	$141.86	$875	$891,239	3.98%
December 2001	$34,340	$141.90	$875	$951,229	3.61%
January 2002	$34,870	$148.20	$750	$1,154,186	3.02%
February 2002	$38,500	$153.39	$875	$1,105,730	3.48%
March 2002	$47,875	$152.96	$875	$1,272,492	3.76%
April 2002	$56,025	$155.63	$875	$1,461,581	3.83%
May 2002	$56,100	$153.70	$875	$1,589,381	3.53%
June 2002	$57,925	$154.06	$875	$1,616,678	3.58%
July 2002	$58,300	$148.72	$875	$1,888,580	3.09%
August 2002	$57,075	$142.69	$875	$1,957,121	2.92%
September 2002	$59,100	$143.45	$875	$1,904,627	3.10%
October 2002	$59,850	$140.82	$875	$2,320,211	2.58%
November 2002	$60,450	$140.91	$875	$2,187,582	2.76%
December 2002	$62,900	$144.27	$875	$2,468,997	2.55%
January 2003	$69,050	$145.37	$875	$2,787,251	2.48%
February 2003	$67,575	$143.78	$875	$2,573,883	2.63%
March 2003	$73,250	$150.72	$875	$2,794,399	2.62%
April 2003	$71,650	$151.16	$875	$2,772,911	2.58%
May 2003	$73,025	$152.14	$875	$2,863,450	2.55%
June 2003	$74,225	$153.04	$875	$2,659,066	2.79%

Attachment H: IRWE and MRE Examples

Examples of Impairment Related Work Expenses (IRWE):

- Attendant care services (at work, for transportation, other)
- Diagnostic procedures
- Durable medical equipment (plus installation, maintenance, and associated repair costs)
- Essential non-medical appliances and devices (electric air cleaner, etc.)
- Exterior home modifications that allow access to the street or to transportation (ramps, railings, pathways, etc.)
- Interior home modifications which create a work to accommodate impairment (enlargement of doorway, etc.)
- Interpreter (at workplace)
- Job Coach
- Medical devices
- Measuring instruments
- Mileage allowance (to and from work)
- Modified audio/visual equipment (enlarged monitor, speech activated computer, etc.)
- Pacemakers
- Physical therapy
- Prostheses
- Reading aids
- Regularly prescribed medical treatment or therapy and physician's fees associated with this treatment
- Respirators
- Routine prescription drugs
- Special work tools
- Traction equipment, braces
- Typing aids
- Vehicle modification (plus installation, maintenance, and associated repair costs)
- Wheelchairs
- Work animal and associated costs (plus food, maintenance, and veterinary services)
- Workspace modifications (adjustable desk, etc.)
- Work subsidy (increased supervision, etc.)

Examples of Medical Remedial Expenses

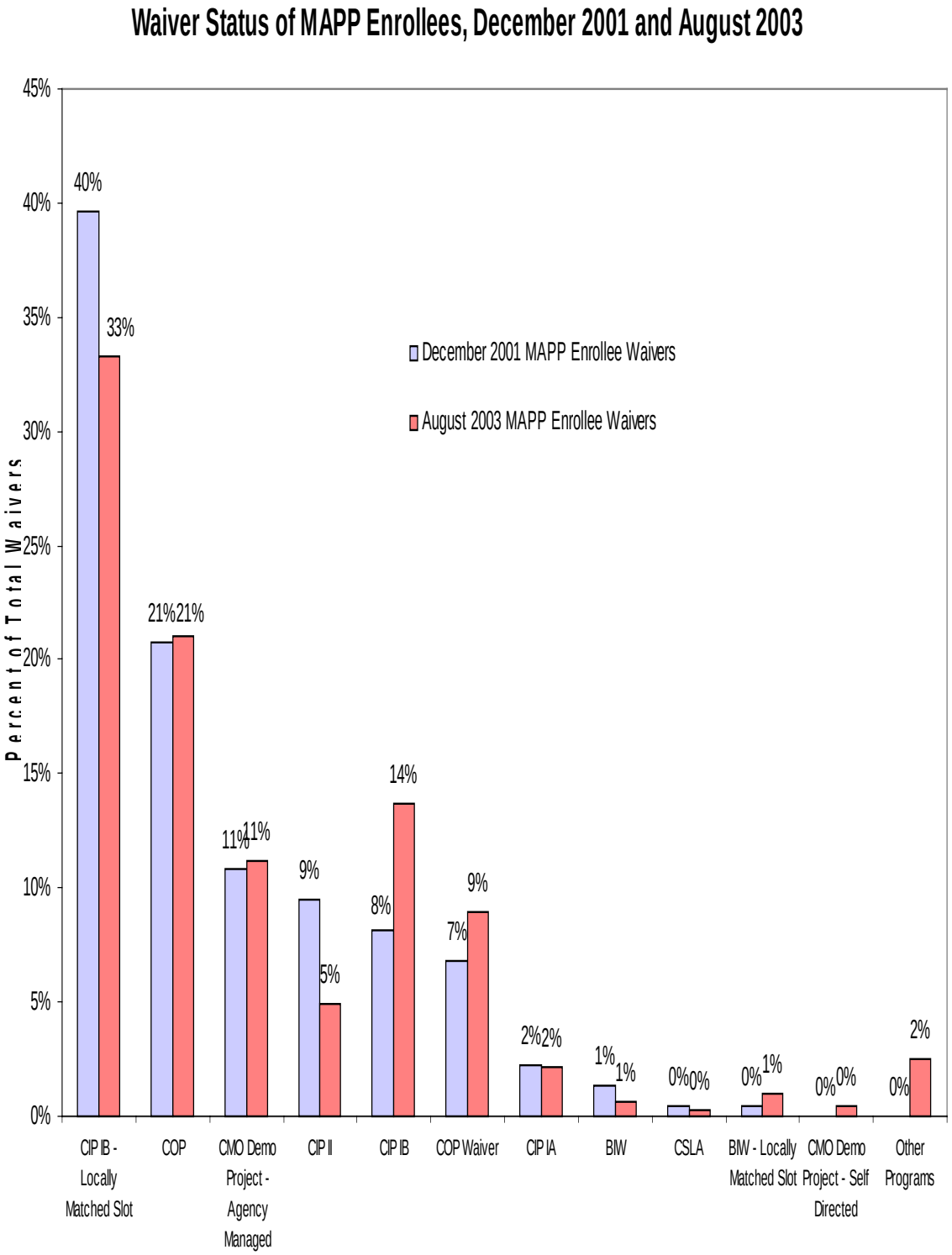
- Abdominal supports; Back supports
- Acupuncture
- Artificial teeth, eyes, limbs
- Attendant care (at workplace or other)
- Audio/visual equipment, such as screen magnifiers
- Automobile or van modification
- Automobile modified equipment; Autoette
- Bathtub/Shower accessibility modifications and
- related adaptive hardware
- Bed pads; Bed boards
- Chiropractor
- Computer/desk modifications
- Convalescent home
- Diapers
- Dietician/Nutritionist Services or Information
- Elevator
- Eyeglass prescriptions
- Excess energy costs related to a medical condition
- Handrails
- Healing services
- Health institute fees
- Health spa
- Hearing aids
- Home improvements made for medical reasons: air conditioning system, bathroom on the first floor, ramps, doorway modifications, etc.
- Hydrotherapy
- Inclinator or other device for managing stairs
- Invalid chair
- Job coach
- Life-care fee (medical portion only)
- Lodging on trips to obtain medical care
- Medicaid co-payments
- Medical supplies
- Modified clothing
- Modified eating utensils
- Outstanding medical bills
- Practical/other nonprofessional nurse for med services
- Prescription drugs
- Private health insurance premiums
- Reclining chairs
- Registered nurse
- Rental of medical equipment
- Repair of special medical equipment
- Respite care
- Special mattresses
- Special plumbing fixtures
- Special telephone equipment and associated repair costs
- Special technology needs
- Transportation costs for medical visits
- Vitamin Supplements
- Wheelchair; other equipment
- Wages of guide/assistant
- Whirlpool
- Work animals and associated maintenance costs (plus food, maintenance, and veterinary services)

Attachment I: Regression Analysis of MAPP and Comparison Group Expenditures

Regression Coefficients for Spending Per Person Per Month by Category of Service								
	Drug Spending		**Capitation Spending**		**Inpatient Spending**		**Outpatient Spending**	
Intercept	$156		$517		$2,901		$126	
MAPP High Wage	-$4	NS	$177	NS	-$655	NS	-$44	
Trend – MAPP High Wage	$0	NS	$32		$48	NS	$1	NS
MAPP Low Wage	$27		-$57	NS	-$361	NS	-$3	NS
Trend – MAPP Low Wage	$1		$17		$26	NS	$0	NS
Months Elapsed	$2		$8		-$17	NS	-$1	
No Prior Medicaid	-$75		-$147		$2,988		$114	
Trend – No Prior Medicaid	$1	NS	-$8	NS	-$194		-$5	
CDPS Index	$111		$10	NS	$612		$67	
Medicare Eligible	$86		$2,245		-$3,592		-$129	
Third Party Insurance	-$42		$727		-$829		-$66	

Regression Coefficients for Spending Per Person Per Month by Category of Service						
	Professional Spending		**Home Health Spending**		**Total All (non-Institutional) Spending**	
Intercept	-$73		$440		$626	
MAPP High Wage	-$33	NS	-$37	NS	-$305	
Trend – MAPP High Wage	$0	NS	$5	NS	$14	NS
MAPP Low Wage	-$3	NS	-$217		-$154	
Trend – MAPP Low Wage	$0	NS	$1	NS	$4	NS
Months Elapsed	$0	NS	$2	NS	$1	NS
No Prior Medicaid	$25	NS	-$357		$436	
Trend – No Prior Medicaid	-$3		$2	NS	-$35	
CDPS Index	$187		$7	NS	$673	
Medicare Eligible	-$14	NS	$228		-$419	
Third Party Insurance	$139		$256		$127	

Attachment J: Waiver Status of MAPP Participants, December 2001 and April 2002



Attachment K: Waiver Status of MAPP Participants

Waiver Status of MAPP Enrollees

	December 2001	August 2003
Monthly MAPP enrollees	1,714	4,792
% of MAPP enrollees with waivers	12.5%	18.9%

LTS Code	LTS Name	December 2001 MAPP enrollees with December 2001 waivers[1]	% of Total December 2001 waivers	August 2003 MAPP enrollees with August 2003 waivers	% of Total August 2003waivers
8	CIP IB - Locally Matched Slot	88	39.6%	378	33.3%
7	COP	46	20.7%	239	21.0%
C	CMO Demo Project -Agency Managed	24	10.8%	127	11.2%
2	CIP II	21	9.5%	56	4.9%
4	CIP IB	18	8.1%	156	13.7%
3	COP Waiver	15	6.8%	102	9.0%
1	CIP IA	5	2.3%	24	2.1%
6	BIW	3	1.4%	7	0.6%
5	CSLA	1	0.5%	3	0.3%
B	BIW - Locally Matched Slot	1	0.5%	11	1.0%
D	CMO Demo Project - Self Directed	-	-	5	0.4%
9	Other Programs	-	-	28	2.5%
	Sum of all waivers	222		1,136	
	Unduplicated Enrollee Count[2]	214		905	

[1] MEDS eligibility data was queried to find December 2001 MAPP enrollees. HSRS LTS data was then queried to identify those MAPP enrollees who also had waiver eligibility in December 2001.

[2] A number of MAPP Enrollees were eligible for more than one waiver in a given month.

Attachment L: Disability Status of a Sample of MAPP Participants

Body System Code	Body System Name	Frequency	Percent
12	Mental	1,170	58.9%
1	Muscoloskeletal	231	11.6%
11	Neurological	200	10.1%
9	Endocrine and Obesity	70	3.5%
Blank	Blank	67	3.4%
4	Cardiovascular	64	3.2%
2	Special Senses and Speech	51	2.6%
3	Respiratory	34	1.7%
13	Neoplastic	28	1.4%
5	Digestive	24	1.2%
14	Immune	17	0.9%
6	Genito-Urinary	16	0.8%
7	Hemic and Lymphatic	5	0.3%
10	Multiple Body Systems	5	0.3%
20	Undetermined	3	0.2%
8	Skin	2	0.1%
15	Blank	1	0.1%
Total		**1,988**	**100.0%**

Criteria: Using the latest (most recent) disability determination with at least a body system code, or 1 of 2 diagnoses codes, 1,988 SSNs of 2,074 unique participants matched these criteria.

Diagnosis Code 1	Diagnosis	Frequency	Percent
2960	Manic Disorders	306	15.4%
2950	Schizophrenic Disorders	294	14.8%
Blank	Blank	281	14.1%
3180	Other Specified Mental Retardation	202	10.2%
7150	Osteoarthrosis and Allied Disorders	78	3.9%
2940	Other Organic Psychotic Conditions	67	3.4%
3000	Neurotic Disorders/Anxiety States	52	2.6%
2780	Obesity	49	2.5%
3010	Personality Disorders (Paranoid)	44	2.2%
3195	319-Unspecified Mental Retardation	34	1.7%
4140	Other Chronic Ischemic Heart Disease	25	1.3%
3400	Multiple Sclerosis	24	1.2%
7140	Rheumatioid Arthritis	24	1.2%
4960	Chronic Airway Obstruction (not elsewhere classified)	21	1.1%
7280	Disorders of Muscle, Ligament, and Fascia (Infective Myositis)	20	1.0%
3430	Infantile Cerebral Palsy (Diplegic)	19	1.0%

Diagnosis Code 2	Diagnosis	Frequency	Percent
0		427	21.5%
Blank	Blank	281	14.1%
2960	Manic Disorders	170	8.6%
6490	Insufficient medical evidence available to establisha Dx	128	6.4%
3010	Personality Disorders (Paranoid)	104	5.2%
3000	Neurotic Disorders/Anxiety States	91	4.6%
7150	Osteoarthrosis and Allied Disorders	68	3.4%
2500	Diabetes Mellitus	53	2.7%
7240	Other and Unspecified Disorders of the Back	52	2.6%
2480	Dx Established, does not correspond to a specific code	51	2.6%
3030	Alcohol Dependence Syndrome	48	2.4%
3450	Epilepsy (Generalized Nonconvulsive Epilepsy)	44	2.2%
2780	Obesity	37	1.9%
3180	Other Specified Mental Retardation	28	1.4%
2950	Schizophrenic Disorders	24	1.2%
4010	Essential Hypertension	24	1.2%
3195	319-Unspecified Mental Retardation	21	1.1%
7280	Disorders of Muscle, Ligament, and Fascia (Infective Myositis)	21	1.1%
2940	Other Organic Psychotic Conditions	20	1.0%
4140	Other Chronic Ischemic Heart Disease	19	1.0%